Physician Rurrows Clare /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MOSPITAL SINAI BALTIMORE OF ALTIMORE C der 1 Year | If Under 24 Hrs. f Under 1 Year 8. Date of Birth (Month, Day, O7 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 212-34-6650 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at Baltimore Director MD NA 10e. Street and Number 10f. Zip Code ö 21215 or items 23a 5033 Denmore Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Baltimore, Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 🎇 Divorced 'natural' Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse 12th grade 2yrs 17. Father's Name (First, Middle, Last) Be Rosa Taylor Kelly Smith Sr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) Yolanda Burrows Holmes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6.30.2007 1X Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 6/26/07 4 ☐ Donation 5 ☐ Other (Specify) nature of Emperal Service Licen 22. Name and Address of Facility March F/H West e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Enter the disease. 23a, Part1 shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) - NCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner ROLONGED POGLYCEMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans requires that the death certificate be exec Due to (or as a consequence of) Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Completed 24a. Was an , page 2 certificate 1∐ Yes Physician; 25. Was case referred to medical director Be examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) o the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? Certification; 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certi 2

1 - State Amend 20b, perFH, G868, 6.29.07 TT

1. Decedent's Name (First, Middle, Last) Giara L. Burrewo 2. Date of Death 3. Time of Death Clara L. Burrows Day Year Month 1155 A 25 200% 4c. County of Death Year) 35 Birthplace (State or Foreign Country) NC 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black White etc. Specify: Black 16b. Kind of Business/Industry Private Duty 18. Mother's Name (First, Middle, Maiden Surname) Daughte 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Vernard La, Georgetown, SC 29440 20c. Location - City or Town, State Randallstown, Md 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death DAYS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) person who completed cause of death (item 23a) (Type, 31. Date filed (Month Day, Year)

JUN 2 9 2007 Nelson

State Registrar 30. Name and address

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per*ID, 889, 7/9/07 IT AMEND TITE FOR THE STATE OF Health and Mental Hygiene

Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24 2007 B:00a. Bolling June Linwood 0. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Liberty Heights Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 73 Director 09 225-34-9505 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5626 Groveland Funeral Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Heavy Equipment Operator Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bolling Ethel Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie E. Bolling-Wife 5626 Groveland Ave, Baltimore, Md
20 of Disposition (Name of Date 200. Location - City or 21215 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/29/07 | Randallstown, Md ure Funeral Service Lie 22. Name and Address of Facility March F/H West Jahan 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o 21215 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinomo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2|**2**|No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗖 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State

DHMH 17 Rev 1/2001

To the within 2

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SANDHU

JUN 2 9 2007

1940 32. Registrar's Signature

PHYSI (IAN

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

57543

W. BALTIMURE ST. BALTIMURE, MD 21223

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Virginia Brown 12.30 p Jun 25, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Manor Care-Roland Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🙀 F Director 214-14-7008 Jan 27, 1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt: If Hem 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show adioal Examiner must be notified at 1 XYes 2 No Directo N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6143 Chinquapin Parkway U.S.A. 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housekeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Jones Unknown ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6143 Chinquapin Parkway Baltimore, Maryland 21239 Department of Health Important: If Item 27 any Injury or other tr Antoinette Watkins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/02/07 Windsor Mill. Md. King Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 212
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) physician the buria Division or Vital Records, P.O. Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9□ Unknown g ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed. 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes PZ No 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending (Month, Day Year) Natural Natural Injury 5 Pending s after dec...
seral Director; β
if filled in by the 1 TYes 2 TNo investigation 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 64493 raddress of person who completed cause of death (Item 23a) (Type, Print) street, #308, Baltimore, m22/20/ Maria 31 Date filled (Month, Day, Year) State JUN 2 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 24, 3:50 A. M June 2007 Elva Best /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Montgomery Hospice Casey House 8. Date of Birth (Month, Day, Yo If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Days Months Hours 1 □ M 2 🔀 F 1923 Pennsylvania 84 192-14-4767 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

• marked other than "naturat", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Rockville Director Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20851 1118 Maple Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No. Specify: White Saltimore, Maryland 21215-0036 Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Ruth Viola Best <u>Harry</u> Fisher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7753 Graybill Dr., Harrisburg, Pennsylvania 17112 Laurie E. Wiest / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: if iter any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State June 30, 2007 Bloomsburg, Pennsylvania 4 □ Donation 5 □ Other (Specify) Elan Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility bert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) **Physician** Peritonitis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page certificate 1⊟ Yes 2 1 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 KOther (Specify) Hospice Hospital: 3□ DOA 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 2 After this funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 ☐ Pending investigation 1 X Natural М 1 □ Yes 2 □ No r death. Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

30

State Registrar

31. Date filed (Month, Day, Year) JUN 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Anne Wroblewski, M.D., 6001 Muncaster Mill Rd., Rockville, MD 20855 2. Registrar's Signature

June 27, 2007

DHMH 17 Rev 1/2001

Registrar

JUN29

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Jeannie M. Carroll June 25 8:10 P M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center <u>Annapolis</u> Anne Arunde1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Days 1□M 2√F Months 49 Yrs. 218-70-2265 July. 30 1957 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 ☐Yes 2 No Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1588 Crownsville Rd. 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th O Janitora1 Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wilson Bernice Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Carroll(Husband) 1588 Crownsville Rd. Crownsville, Md.21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6-30-07 Baltimore, Md. 21. Signature of Funeral Service Licensee Minima Reductions of Eacilia ons Mortuary, Larry 821 West St. Annapolis, Md. 21401 1100483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kight Middle Cereby Onset and Death Cereprolascula Acciden resulting in death) D to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death pani 23d. Date of delivery 3 □Ectopic pregnancy Month 4☐Pregnant at time of death Day 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | No 1 Hpatient 2 ER/Outpatient 3 DOA 27. Man of Death

Physician /Medical Examiner

Department of H Important: If ite any injury or of

permit.

Physician

Examiner

Funeral

Director

Show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

other treumatic event, the Medical

Pages 1 and 2 should be filed inent of Health end Mental Hygint: If item 27 is marked other

within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Be

ပ

/Medical

inding physician and use as the burial-transit the attending physician for be detached signed by peen has within 24 hours after death.

To the Funeral Director: After this certificate

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

filled in by the funeral

Physician/Medical þ Completed Be ^o

Examiner Certification: Medical

IF FE	EMAL	E:		
23b.	Was	dece	dent	preg
		e past		
	10	Yes	21	No
	<u>.</u> П	1-1		

Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Medal Center AnnapolisMD ZU401

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Date of Injury

(Month, Day Year)

29c. License number D0005829

29d. Date signed (Month, Day, Year) 26/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWATZ D MO bung Anne

0 31. Date filed (Month, 32. Registrar's Signature 9 200

5 Pending investigation

6 Could not be determined

28b. Time of

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25, 2007 Month JUNE 4:48A M NANCY MARIA CLOMAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Baltimore Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours 1 ☐ M 2 🕱 F 1958 Puerto Rico Mar. 18, 49 215-88-5292 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21001 4612 Old Philadelphia Road 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married tx Yes 2 □ No Specify: 3 ☐ Widowed 4 ☐ Divorced Puerto Rican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alejandrina (nmn) Lopez Erasmo Agelardo Garcia-Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 19a. Informant's Name/Relationship (Type. Print) 4612 Old Philadelphia Road, Aberdeen, Maryland Edwin R. Cloman Jr. /Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Grdn 6-28-07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu neral service Licens McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 DAYS Immediate Cause (Final disease or condition resulting in death) ASPERGILLOSIS PNEUMONIA Due to (or as a consequence of) LYMPHOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy perform 2**/2** No 1∐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

la or 28a-f show t be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-any Injury or other traumatic event, the Medical Examiner must be notify any once.

Baltimore, Maryland 21215-0036

Director

Funeral

δ

Completed

Be

Maryland

and use as the burial-trar attending physician for use as the buria detached þ After this certificate has been signed in funeral director, page 2 should be det

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital 24 hours a

within 24

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical 2 Completed Be Certification: To ospitar 4 hours after dea...
-vral Director; After Medical To the Fune completely f

9 Unknown

IF FEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PANCYTOPENIA

26. Place of Death (Check only one)

	1 ☐ Yes	2 X N	0
27.	Manner of		
	1 DM Natur.	al	

3 Suicide 4 Homicide

25. Was case referred to medical

5 Pending investigation 2 Accident 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifieg (Check one)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OSLER DRIVE TOWSON,

29b. Signature

Hospital:

29c. License numbe D35453

29d. Date signed (Month, Day, Year)

MARYLAND 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

LINDA FREDA BARR

31. Date filed (Month, Day, Year) JUN 2 9 2007

7601 M.D. 32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 **Physician** June 24, 9:55 P.M Chang Sun Choi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1⊠M 2□F Yrs. March 25, 81 1926 103-38-6821 Korea Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shovidical Examiner must be notified at 1 Tyes 2X No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 11321 Freas Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced Asian 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physicist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be : If Item 27 Is marked or other traumatic ev Byuck San Choi Bong Hack Lee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11321 Freas Drive, Gaithersburg, Maryland 20878 Young Joo Choi / Wife Department of Heali Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐Removal from State June 29, 2007 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium Inc. Bethesda, Maryland 21. Signature of Funeral Service Licenses Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850 hase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part1. Enter the disparation of the control of Immediate Cause (Final disease or condition resulting in death) 1 day Intracranial Hemorrhage **Physician** /Medical Due to (or as a consequence of): Examiner Fall with Head Injury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Fell 1900 M 1 ☐ Yes investigation Jun 22, 2007 2 Accident death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 32 / Cyec.5 Dr. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

> 10 State

Registrar

Medical

Brandon 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come 9901 Medical Center Drive, Rockville, Maryland 20850

JUN 2 9 2007

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064029

29d. Date signed (Month, Day, Year)

June 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician DOFIS 6 8 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMORE Rose MOSDI A If Under 1 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F 220-12-8032 Director JAN 21,1927 MARYLAND Usual Residence of Decedent a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Middle Director MARY/AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a c 3544 21220 HUNCYSUCKIE by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced "natura!", Completed er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KENS CAB SCRUICE CAB DRIVER Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, tonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Deorge ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Honey sickle James 544 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BAHIMORE, MARGAND 21. Signalus A Funeral Service Licensee mine Licenses Hertician Acen 40 BAlto 4D 21224 Highland 420 23a. Part1. Enter the disease shock, or heart failure. proximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** Se o s 's
Due to for as a consequence of): HOURS disease or condition resulting in death) /Medical **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached t 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown CAD 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has by certificate COPD 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Spolle D0063974

Registrar DHMH 17 Rev 1/2001

State

9000 FRANKLIN SQUARE DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DR FMRA Siddi 31. Date filed (Month, Day, Year)

JUN 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20bper ft. 8869 7-6-07 vt. State of Maryland Department of Health and Mental Hygiene. State Registrar Amend 20b, perFH, 0869, 7/9/07 TT Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician Diane JUNE 27, 2007 11:03 P^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day | Hous | Min. | Hug | Io 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F 36 USVI 1970 580 03 1286 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Mudical Examiner must be notified at 1 Yes 2 □ No Funeral Director NIA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21239 USA 5507 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned ŏ 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) ollege (1-4or 5+) Secretary Holministrative ayrs. In Clark 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Heelth end Mental Heelth end Mental H Dawn Francis Laniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth er Important: if item 27 is any injury or other trau P.O. BOX 305776 Dahlia Percival St. Thomas USVI DOBO3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 7/12/2007 1 ABurial 2 Cremation 3 Removal from State 4 Onation 5 Other (Specify) * ST. Thomas USVI Western Cemetery 21. Signal of Funeral Se permit. Promitted Funeral Home P.A. Fredhilton Ross BALTIMOREMO 21229 Approximate Interval Between Onset and Death Party Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fee a Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the dear certificate be executed Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? hes 1 Yes 20 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No

27. Manner of Death
1 S Natural
2 Accident Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 28b. Time of 28c. Injury at Work? Aftert Certification: 28d. Describe how injury occurred 5 Pending death, 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date/signed (Month, Day, Year) 30. Name and N.CHARLES ST. 32. Registrar's Signature State Registrar

anendment

39

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day June 25, 2007 0713 hrs Medical Examiner Davis Frederick 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Laurel Regional Hospital Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Davs Hours Director $\frac{-43}{-72}$ Country) 11-8-1968 1 X M 2 F 38 Yrs Conn. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 X No Mitchellville 28a-f show Md. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 USA 1104 Kingsdale Ct. 23а Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No If Yes, Give Year 3 Widowed 4 Divorced Yes 2 X No specify: Specify: Black ⋧ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " within 72 21215-0036 Disabled NΑ 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hancock Davis Esther Frederick Roland Be Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD .92 1104 Kingsdale Ct., Mitchellville, Md. Faye A. Davis Sister If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Pages 1 Burial 2 X Cremation 3 Removal from State 7-02-07 Greenmount Cem. Baltimore, Md. mportant: Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ame and Address of Facility March F. H. East 1101 E. North Ave., Baltimore, 21202 Wane 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line. /Medical Death Complications of remote blunt head injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - trans Physician/Medical X UNPENDED #MENDED, 28a-f, perME, g871, 9/19/07 TT X death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months Pregnant at time of death 5 Other (Specify) ned by the atte detached for u 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. requires that ð σ. Yes 2 ✔ No 3 Probably 4 Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? 2 No certificate ✓ Yes 2 ✓ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this Certification: To 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Natural Yes 2 X No Director: Pending subject assaulted 2/19/1999 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) Could not be Suicide determined the Funeral (Specify) 4 X Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Lo. and manner stated Signature and title 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 26, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month 32. Re State 9 200

DHMH 17 Rev 1/2001 OCME 2006

Registra

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 12:05 P M 24. June Laura Marquerite Finney Dance /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 1932 Maryland 24. 74 Nov. Director 218-32-7144 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location show 10a. State 10b. County a or 28a-f show be notified at 1 ☐ Yes 2X No Director Maryland Bel Air Harford 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 23a or USA 21014 105 Glenmore Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Mary Land Horsebreeders Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Association Copy Editor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Marquerite Macey Humphrey Stanley Finney ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 105 Glenmore Court, Bel Air, Maryland 21014 Iaura Alexander / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐ Bemoval from State 6-27-07 Towson, Maryland Hilltop Service Corp (Specify) 4 Donation 5 □ Ott McComas Funeral Home, P.A. 21. Signa un of Funeral 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line 1/1=20 Immediate Cause (Final disease or condition resulting in death) Physician eque /Medical orice of): Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown led by the a us certificate has been signed by director, page 2 should be detacl Part II. Other ficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, son 3 2 1 | Yes 2 | No 3 | Probably 4 | Sknown Completed 1/20/000 16011EM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 13/2/-1□ Yes Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Bursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Division or this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a Date of Injury Certification: 27. Manner of Death After the Hospital or Attending I hin 24 hours after death. the Funeral Director: After (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide determined filled in by 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30260 F S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 EDDIE NAKHUDA, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 JUN 29 BURS A Registrar

2:05 P.M

2007

MARGUERITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 21 2007 1109 June Rosie Dailey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A University of Maryland Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Months Days Min 1 □ M 2 🖳 Maryland Oct 2, 1938 Director 213-36-1480 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has a 12 is marked other than "natural"; or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Pasadena Directo Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 64 Magothy Beach Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐. If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Physician Office Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hall Clarence A. Hall ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trauonce. 64 Magothy Beach Road Pasadena Melvin Dailey Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ ★Gurial 2 □ Cremation 3 □ Removal from State 06/28/07 Pasadena, Md. 4 ☐ Donation — 5 ☐ Other (Specify) Mt. Zion Church Cemetery 21. Sistature o Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md. 21217 Approximate Interval Between Onset and Death disease, or complications that caused the failure. List only one cause on each line. Do not unter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the shock, or hear Immediate Cause (Final SCALC Physician irona disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23d. Date of delivery 23c. If ves. outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 ER/Outpatient 3 DOA 1 Tyes Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) nd title of cartifier 29b. Signature

State Registrar 30. Name and a

Anu

31. Date filed

ohth, Day,

DHMH 17 Rev 1/2001

Jacks Dr. Pages

GRETENE

32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

25.

ORIGINAL

Bacto, MD

2120

			For State	State of M	laryland	•				and M	lental Hyg	giene	10.7	210	1 1,
			Registrar 1. Decedent's Name (First, Middle,	(act)		Cer	tificate	Of L	Jeath		2. Date of Dea	Reg. No:	101	3. Time of De	ath
	Physicia			e veuc7							Month 6	Day	2007.	5:15	
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, T	own, or	Location of	of Death	0.6	4c. Cou	nty of Death		
			RIVERVIEW CA					ESSI					ALTI		
	Funeral		, , , , , , , , , , , , , , , , , , , ,	6. Sex 7. A 1 ☐ M 21X☐ F	ige (In yrs. las 87	t birthday) Yrs.	If Under 1 Months	Days Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)	Col	place (State or F Intry) RYLAND	oreign
	Director	-	217-18-9038 Usual Residence of Decedent		0 /	7.0.					01-18	-14 60	MAI	(I DAND	
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City I	
:	Ba-fs	cto	MD N	I/A	В	BALTI	_							1 X Yes 2	
:	a or 2	Dire	10e. Street and Number	3.17031110			10f. Zip (224			10g. Citizen		_	
	eath y	Funeral Director	3816 FOSTER 11. Marital Status	AVENUE 12. Was Deceden	t Ever in U.S.	13. V	Was Decede		224 spanic Ori	gin? (Sp	ecify Yes or No-		U.S.A		
,	r Itan	F	1 ☐ Never Married 2 ☐ Marrie	Armed Forces ad 1 ☐ Yes 2 🔀	?						ecify Yes or No- Rican, etc.)	i	Black, White	, etc.	
3	rel', o	l by	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates	:		1□Yes 2	X NO	Specify:			Spe	cify: WI	HITE	
5	"netu	Completed by	15. Decedent' (Specify only highes)	s Education t grade completed)	į	16a. Deced	tent's Usual kind of world DO NOT use	k done di	urina mos	t of work	ing	16b. Kind o	f Business/I	ndustry	
7	within ane. then	duc	Elementary/Secondary (0-12)	College (1-4ci	r 5+)		OUSE					D	OMES	ric	
2	should be filed within 72 hours atter death with the Maryland and Mental Hygiene. "Hygiene" heturet, or Itams 23a or 28a-f show marked other then "heturet, or Itams 23a or 28a-f show imatic event, the Medical Evanting ruusi Lee Folithed at	a	17. Father's Name (First, Middle, L	.ast)					18. Mothe	er's Name	e (First, Middle,	Maiden Sun	name)		
g	uld be Menta Irked Itic ev	To B	GEORGE C	OEB						ELEI		USES			
_	2 should ba fi and Mental H Is marked of reumatic ever		19a. Informant's Name/Relationsh											ip Code) 212	.08
≥ 15	is 1 and of Health item 27 other tr		RONALD DERENCE 20a. Method of Disposition	ZZ/ SON	20h Plac	8508 ce of Dispo			INHO		DRIVE	PIKE 20c. Location			
5	Pages I		1 X Burial 2 Cremation		e cen	netery, cren	natory or ot	her place							T 7 NT
			* 4 □ Donation 5 □ Other (Sc 21. Signature of Funeral Scales b		SACK									RE, MARY	LANI
ğ	parmit. Departr Importe eny inji						ILLY 00 S	. & c	ZEIL	ER ING	INC F	UNERA L.BAL	$\frac{1}{10}$	4E 4D. 212	24
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death.									Approximate Interval Betwe	en
F	Physician		Immediate Cause (Final disease or condition		recet	C								Onset and Dea	ath
	/Medical Examiner		resulting in death)	a	s a conseque	nce of):								4 -	
ľ	LAGITITIES	_	Sequentially list conditions,	b. Due to (or a	is a conseque	nce of):									
١.	itad nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or miury that initiated events	Due to (01 a	is a conseque	1100 01).									
5	be executad Ician and burial-transit	Exal	resulting in death) Last	Due to (or a	is a conseque	nce of):									
-	ys e	icai		d											
	artifica ing ph e as th	Physician/Med	IF FEMALE:										1200		
200	ath ce attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		ne of pregnand 2 ☐ Fetal d at time of dea	eath 3	Ectopic pre					23d.	Date of deli Month	very Day Yea	ar
5	the de	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unknown		un 5L] Other (spe								
Ţ.	Attending Physicien: The law requires that the death certificate be executed in death. **r death.** actor: Atterthis certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant condition	ns contributing to death	but not result	ing in the u	nderlying ca	ause give	n in Part I		23e. Did t	obacco use o	contribute to	the cause of dea	ith?
cords,	quires an sign uld be	ed b	Myperteina	ns contributing to death	seclee	she (سان ۱۰ ت	إسع	O pec	zektee!	10,	Yes 2□N	o 3∏Pr	obably 4 🖯 Uni	known
) (၁	law re as bec 2 sho	ompieted	Hyperligido	oria							24a. Was autor	osy	prior to o	topsy findings av	ailable se of
	The ate h	Соп									perfo	rmed? 2⊟No	death?	2□ No	
VII	sicien: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only o				
5	Phys this ral dir	L.	1 Yes 2 No 27. Manner of Death	1 🗀 Inpa		R/Outpatier				ursing Ho	ome 5 Residence			cify)	
202	tending Physicien: leath, tor: After this certific tha funeral director,	tion	1 Natural 5 Pending		Day Year)	Injury	М	8c. Injury Work 1 ☐ \	(? ∕es 2□	No					
	Atter	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place of I	Injury - At hometic. (Specify)	ie, farm, str	eet, factory	, office			28f. Location (. City or Tox	Street and N	umber or Ru	ral Route Numbe	er",
5	talor rs afte al Dir ed in	Cert	* E riomicido	building,											
	To the Hospital or Attendi within 24 hours after death, To the Funeral Diractor: A completely filled in by tha fu	edicai	(Check only 2 Medical I	g Physician: To the bes Examiner: On the basis	of examination	ledge, deatl on and/or in	h occurred a vestigation,	at the tim in my or	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	i manner as ce, and due	stated. to the cause(s)	
	thin 2 the or the	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c	. License	number			29d. Date si	gned (Mont	h, Day, Year)	
	- 3 - 8		Micerose Re	(Legions)	-		T	2001	067			06 -	28-7	007	
	^		30. Name and address of person		f death (Item 2	23a) (Type,	Print)								
	10		MICHAEL SCHW				CHIE	HWY	, si	JITE	608,6	LEN I	BURNI	E,MD 2	1061
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	re			•						
	Regist	rar	JUN 2 9 2	007 Alama	· H	5084	w								

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State of Mar		rtment of Health tificate of Deatl			J. No. 1	21015
		_	1. Decedent's Name (First, Middle, Last)				Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Warren L. Dean				une 27,		6:45 A. M
)	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	on of Death		4c. County of Dear	
	<u> </u>		Manor Care Potomac	(In the last blinth day)	Potomac If Under 1 Year If Under	der 24 Hrs. 8	. Date of Birth	Montgome	
16	Funeral Director		5. Social Security Number 483-05-9520 6. Sex 1 ▼ M 2 □ F	(In yrs. last birthday) 90 Yrs.	Months Days Hours	rs Min.	(Month, Day, Y	1916 Iow	thplace (State or Foreign ountry) 3
	pe ,		Usual Residence of Decedent	10c. City, Town or Lo	cation				10d. Inside City Limits
	anylar show	5	, said	Bethesda	cation				1 □Yes 2√∑No
	the M	ect	Maryland Montgomery 10e. Street and Number	Dechesaa	10f. Zip Code		100	g. Citizen of What Co	ountry?
	with a sa or a tabe n	Funeral Director	9908 Fernwood Road		20817			ited Stat	
	ms 2%	Jera	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	I Was Decedent of Hispanic (f Yes, specify Cuban, Mexic	Origin? (Speci	fy Yes or No-	14. Race - Ame Black, Whit	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. It was 23 a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No Speci		can, etc.	Specify: Wh:	
Š	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during m DO NOT use retired)	most of working	11	6b. Kind of Business	/Industry
21215-0036	within 7 iene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) [icer			entral Intel	ligence Agency
2	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)			other's Name (i		aiden Surname)	<u> </u>
Maryland	should be filed w nd Mental Hygie marked other t ımatic event, th	To Be	Rae Dean		Cora	a Wiggi	ins		
lary	2 shou and M is mai		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Nur				
	s 1 and 2 of Health a item 27 is other trai	li	Robbie L. Dean / Wife 20a. Method of Disposition	9908 20b. Place of Dispo	Fernwood Road	Dat		Oc. Location - City or	
nor	Pages nent of h int: If ite iry or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei	matory or other place) Crematorium, Inc	June 28,	2007	ethesda,	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service	22	2. Name and Address of Fa	acility v Funeral	l. Home/Roo	ckville, Inc	
	20 E 8 0				0 W. Montgom				Approximate
k	Physician [®]		23a. Part1. Enter the disease, or complications that caused t shock, or heart hailure. List only one cause on each line Immediate Cause (Final						Interval Between Onset and Death
	/Medical		an activities in algorith)	consequence of):	- NCEFE				
3	Examiner		Sequentially list conditions, b.	TROKE	-				
	B K tig	Examiner	Cause (Disease or injury	consequence of):					
Ć.	execu in and ial-tra	Exar	that initiated events c.	consequence of):	*		· · · · · · · · · · · · · · · · · · ·		
38760,	ficate be executed by physician and stransit is the burial-transit	edical	d						
_	ertifica ling ph se as t	Med	IF FEMALE: 23c. If yes, outcome p	of pregnancy		-		23d. Date of de	Nivory
Box	death certifi e attending ed for use as	Physician/M	in the past 12 months?	Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
O.	0 0 0	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
s, P	ss this	by Pl	Part II. Other significant conditions contributing to death but	t not resulting in the u	inderlying cause given in Pa	art I.			to the cause of death?
ord	w require been sign						1 \(\text{Ye}		Probably 4 Unknown
Records,	e law has b	Completed					24a. Was an autopsy perform	y prior to ned? death?	autopsy findings available completion of cause of
a			25. Was case referred to medical		26 P	Place of Death	1□ Yes 2 (Check only one	No 1 ☐ Ye	s 2MNo
Vital	Physician: - this certific ral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatie	Othor	-		nce 6 □Other (Sp	ecify)
ס ר			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day)			_		w injury occurred	
sior	Attending r death. ector: After by the fune	atio	2 Accident investigation		M 1 ☐ Yes 2		0. 1		Donal Davida Miranha v
Division	l or Attend after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inju building, etc	ry - At home, farm, st . (Specify)	геет, тастогу, опісе	20	City or Town	reet and Number or I , State)	nurar noute inumber,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner star	examination and/or in	th occurred at the time, date	ite and place, a i, death occurre	nd due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier	1	29c. License numb	ber	29	9d. Date signed (Mo	nth, Day, Year)
	,		I will	Nu	H00.	5128	00	le -27.	7005
	15		30. Name and address of person who completed cause of de	eath (Item 23a) (Type	, Print)			kwilla M	D 20850
	,		Anushiravan Dadgar-Dehkordi 31. Date filed (Month, Day, Year) 32. Registra		ical Center	Dr. #2	UI, KOC	vortre, M	70070
	St. Regist	ate	31. Date filed (World, Day, Year)	18 Anne	E.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **28** Juneth **Physician** Virginia Eleanor Ehrhardt 2007 12:49 PM /Medical 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gildhrist Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F 1934 Maryland 73 216-34-6932 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Parkville Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 8734 Cimarron Circle 21234 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Fox Ridge permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, the ione. Waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Lutz Christian Woodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Heavin Ct PerryHall Maryland 21236 19a. Informant's Name/Relationship (Type. Print) Christian Ehrhardt -San 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State EVANS FUNERALE
CHAPEL—BEL AIR Forest Hill, Maryland 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 06-29-2007 4 ☐ Donation 5 ☐ Other (Specify) 325 York Road Timonium, Maryland 21093 Signature of Funeral Service Licenses PÉACEFÜL ALTERNATIVES CENTER aluca am Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ma Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease o. nijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and bunial-tran Due to (or as a consequence of): physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an page 2 autopsy 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

that the death certificate be executed Box 68760, P.O. Records, Division or Vital

72 hours after

filed within

Maryland 21215-0036

Baltimore,

Certification: filled in by the

6 ☐ Could not be 3 ☐ Suicide

4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6701

N-Charles St. Balt Md 21 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 5205 29d. Date signed (Month, Day, Year)

State Registrar

Medical

completely

29a. Certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sinc



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Month 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Anta L Foster 20 5:30 AM 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1101 St. Paul St. Apt. 711 Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/03/1971 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sax Months 1 M X X 229-04-4323 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County TX Yes 2 □ No MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21202 USA 1101 St. Paul St. Apt. 711 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Health College (1-4or 5+) Psychotherapist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Shirley Woodson Marvin L. Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
1101 St. Paul St. Apt. 711 Ballimore, 19a. Informant's Name/Relationship (Type, Print) Marvin L. Foster 20b. Place of Disposition (Name of cometery, crematory or other place)

Mt. Vlew Cemetery 20c. Location - City or Town, State 20a. Method of Disposition June 23. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Vinton, VA 4 ☐ Donation /5 ☐ Other (Specify) of Puneral Service Licensee 8800 Harford Rd. Parkville, MD Evans and Address of Earling Chapel Cremation Services 21234 23a. Part 1. Enter the disease, thock, or heart failure. L Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. nmediate Cause (Final metastatic breast Cayes menter disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none 1 Yes 25No 3 Probably 4 Unknown

Physician /Medical **Examiner**

burial-transit

as the

physician certificate be

certificate has

Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certific

To the Hospital within 24 hours a To the Funerel C

Physician

/Medical

Examiner

Director

Funeral

Š

Completed

Be

2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at

the Maryland

death

72 hours after

d 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "no

permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m eny injury or other traum

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Examine Physician/Medical þ Completed 2

Certification:

25. Was case referred to medical examiner? 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No.

1 ☐ Yes 3 ☐ 🗘

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)

24a. Was an 2 No Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22 No

26. Place of Death (Check only one) Other: 4 Nursing Home Mediate 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 Tyes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number mo DZ8239 29d. Date signed (Month, Day, Year)

mo 31231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varia

1650 Orlean Davidson

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

and manner stated



DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** VIOLET ESTELLE FATUM JUNE 25 2007 4:40 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 16, 1915 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 X F 92 Yrs 134.09.7416 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 □XYes 2 □ No **Funeral Director** Maryland 10g. Citizen of What Country? U.S.A 10e. Street and Number 10f. Zip Code 21701 6133-D Springwater Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) computers secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Bonds Frederick Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6133-D Springwater Place Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type. Print) Ms. Estelle King Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/30/07 Kingston, NY Montrepose Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 omuneral service Licenses 1400530 Approximate Interval Between Onset and Death **Physician** Due to (or s a consequence of): Day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) the burial-Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending IF FEMALE If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an las | autopsy certificate I 2 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **3**€ 13/10 1 Inpatient P 2 ER/Outpatient 3 DOA 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Acuser 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** .Month 3:52 PM 2007 Rose M. Fino une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | 19, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 1 □ F 84 1922 **Director** 213-18-0170 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 7548 Old Telegraph Rd. USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) the 8 Seamstress Clothing traumatic event. Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any light or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Antonio Mirabile Rosaria Mirabile 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5814 Westchester Hills Ct. Sykesville, MD 21784 Dominic P. Fino, Jr./ son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 06/29/07 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signatur Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Accident Immediate Cause (Final disease or condition resulting in death) erebrovescular **Physician** /Medical Due to (or as a consequence of): Examiner 12aVS ement Sequentially list conditions, if any, leading to infine unit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 9 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manny r of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 ☐ Pending investigation or Attending (Month, Day Year) 1 Matural death. 2 Accident 1 □ Yes 2 □ No hours after death uneral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number D41365 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 27, 2007

State Registrar

31. Date filed (Month, Day, Year)

J20192

32. Registrar's Signature

DHMH 17 Rev 1/2001

356

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Ospital Drive, Glen Burnie, MD, 2106)

	1	For State Registrar	State of Maryland /	-	ment of He ficate of D		d Mental Hy	Reg. N		7 21020
Physicia	n	1. Decedent's Name (First, Middle, Last) James	Gordon	-			2. Date of Domestin	D.	ay Year 2007	3. Time of Death 1:40 pM
/Medica Examine	110	4a. Facility Name (If not institution, give st Gilchrist		4	b. City, Town, or L		eath	4	c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last I			If Under 24	Hrs. 8. Date of Bi Vin. (Month, D May 1.	rth av, Yea 2, 19	9. Bi	rthplace (State or Foreign ountry)
Maryland a-f show iffied at		Usual Residence of Decedent 10a. State 10b. County Md. Carrol 1	County 10c. City, To	own or Locat						10d. Inside City Limits 1 ☐ Yes 2 No
n with the	al Director	10e. Street and Number 1251 Streaker Ro	1 .		10f. Zip Code 217 8	34		10g. C		USA
al', o	by Fur	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ÑYes ≥ □ No If Yes, Give Year or Dates:			panic Origin , Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
hin 72 hou 9. an "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade	cation 16 completed) College (1-4or 5+)		t's Usual Occupat d of work done du NOT use retired)		f working		Kind of Business	
filed with Hygiene other tha		12 yrs 17. Father's Name (<i>First, Middle, Last</i>)	5+	Sys	stem Anal	18. Mother's	Name (First, Middl	e, Maide	en Surname)	currey
hould be d Mental marked o	To Be	William F. Gordo		19b. Mailing	Address (Street a		or Rural Route Num			Zip Code)
and 2 shealth and n 27 is ner traur		Dean Harmon	son	1251	Streakeı		Sykesvil]	e M		1
permit. Pages 1 a Department of Hec mportant: If item any injury or othe	İ	20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	ceme	etery, crema	ion (Name of tory or other place rematory) J	une 26 2007		BAltimor	
permit. Departn Importa any Inju		21. Signature of Fure al Service License	UN 1	7	110 Solle	ers Po	al Home of	2122	ndalk 2	
Physician /Medical		23a. Part1. Enter the disease, or complishock of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		\sim	the mode of dying	, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent							
icate be executed physician and sthe burial-transit	dical		l							
death certifi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3□E	ctopic pregnancy Other (specify)			-	23d. Date of o	delivery Day Year
w requires that to be should be detact	ρ	Part II. Other significant conditions col	ntributing to death but not resulting	ng in the und	erlying cause give	n in Part I.				to the cause of death? Probably 4 □Unknown
ysician: The law requires the law requires the law requires the law rectuits the law rectures the law rectur	Completed			-			l pe	as an topsy rformed s 2 🗹	prior 1 12 death	autopsy findings available to completion of cause of ? es 2□ No
ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	-lospital: 1	R/Outpatient	3 DOA Othe	· · ·	of Death <i>(Check onl</i> sing Home 5 Re		e 6 🖾 Other (S	pecify) Hosper
ding Pt	Certification: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of injury - At home	8b. Time of Injury e, farm, stree		∕at ⊹? Yes 2∐N	o 28f, Location		njury occurred t and Number or	Rural Route Number,
spital or lours after neral Dire		29a Cartifier 1 Gertifying Phy	building, etc. (Specify) sician: To the best of my knowle	edge, death	occurred at the tin	ne, date and	place, and due to t	he caus	se(s) and manner	as stated.
To the Hospital or Attenwithin 24 hours after death within 24 hours after death or the Funeral Director:	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examination and manner stated.		20a Linana	number		204	Data signed /M	anth Day Year)
15	0	30. Name and address of person who c	ompleted cause of death from 23	23a) (Type, P	rint)	for	strond	20	20%	
Sta	ite	31. Date filed (10) 12, 9ea 2007	32. Registrar's Signatur	re	P					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend PI, line B, per MD, g868, 6/29/07 Certificate of Death

Reg. No.

Reg. No. Reg. No, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert Franklin Griffith Jr. 2007 06 12:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 229-34-8672 79 5-3-1928 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 □Yes 2 No Director MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be nonee. 5013 Niagara Rd. 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: à Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Lather 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Franklin Griffith Jr. Elizabeth Pearl Snider 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45775 Mountain Pine Sq.Sterling, VA 20166 Robert W. Griffith/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 6-26-2007 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MD20910 -Rapp Funeral & Crem. Svc. 933 Gist Av. Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) -burialphysician sthe burial Division or Vital Records, P.O. Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9□Unknowr 9 Unknown signed by Part II. Other significant conditions contributing to death! ing in the underlying cause given in Pairt I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown has been sign Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate ha autopsy performed death? 1 ☐ Yes 2 6 No 1∐ Yes 2 N : After this certifical funeral director, I 25. Was case referred 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 4 은 1 4 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1. Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No death. hours after death.

uneral Director: A

siy filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in To the Hospital 29a. Certifier 1 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check or 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

12

State

1)2.

MASREEN 31. Date filed (Month, Day, Year)

JUN 2 9 2007

Washington Adventist Hospital

ark,

lakuma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		•	For Amend Item	4b per of Marylar 4b per of , 2008, 0	9/29 /9/	rtificate of	lealth and M	lental Hyg	ienė () () /	2:022
	Physici /Medic		1. Decedent's Name (First, Middle, La	(maybe	al			2. Date of Dear Month	Day Year 25 2007	5:35a M
	Examin Funeral	er	4a. Facility Name (If not institution git Chaple 5. Social Security Number 6.5	ex 7. Age fin yrs.	Me last birthday)	4b. City, Town, or Honor 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	Baltimor	
	Director		Usual Residence of Decedent	□M 2√x 73	Yrs.		riours with.	July 7	1933 NC	
	the Marylan 28a-f show	ctor	MD 10b. County Carroll	10¢, CI	Sykesi					10d. Inside City Limits 1 Tyes 2 No
	23a or 28	al Director	10e. Street and Number 261 Klee Mill	Road		10f. Zip Code 21784		1	Og. Citizen of What C USA	Country?
920	or thems	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	within 72 iene. rthan "ne	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT use retired Irsing ass	during most of work		16b. Kind of Busines health car	
land ?	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last, Cleamon Forbes)			18. Mother's Nam Flora Wo		Maiden Sumame)	
	nd 2 lith a 27 is		19a. Informant's Name/Relationship (Ray Graybeal (son						t, City or Town, State, $tsville,\ N$	
Baltimore,	00		20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	T-1-		osition (Name of matory or other place Memorial		Date	20c. Location - City of ${\sf Sykesvill}$	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer Page Haight			2. Name and Addre 2.0. Box 1			ral Home 8 D 21784	& Chapel
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line. a					est,	Approximate Interval Between Onset and Death
3760,	cate be executed physician and the burial-transit	lical Examiner	Sequentially list conditions, if arry, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consecution of the consecution	,					
P.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy page 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	lelivery Day Year
ords, P.	w requires that i been signed by should be deta	Ď	Part II. Other significant conditions of Myoch rdi	contributing to death but not res		, ,	en in Part I.	1		to the cause of death? Probably 4 Dunknown
II Reco		Completed						24a. Was a autop perfor 1 Yes	sy prior to med? death?	autopsy findings available o completion of cause of ? es 2 \(\) No
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DOA Oth	26. Place of Deal		ne/ ence 6 □Other (Sp	pecify)
Division of Vital Records,	After After fune	Certification: 7	27. Manner of Death 1 Datural 5 Pending 2 Accident investigation	1	28b. Time of Injury	of 28c, Injur Wor	y at		ow injury occurred	
Divi	tat or Att rs after d al Direct led in by	Certifi	3 Suicide 6 Could not be determined			reet, factory, office		28f. Location (S City or Tow	treet and Number or : n, State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Example)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or in	nvestigation, in my o	pinion, death occur	red at the time, o	late and place, and d	ue to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	amo		29c. Licens	0.		6 2 5-	_
	(A)		30. Name and address of person who SHAttiDA SIDD	+/	m 23a) (Type ∫ Y K	Print)	= RUAL	syte	mile MD	21784
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2007	32. Registrar's Sign	ature	وع				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Mary		rtificate of L		, ,	eg. No:	007	21023
	Physicia	200	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		Year	3. Time of Death
g.	/Medic		John	Henry		Grav		June	24	2007	4:15р м
1	Examin	er	4a. Facility Name (If not institution, given 2020 Featherbeck)	,		4b. City, Town, or Woodl			4c. Ce	ounty of Death Baltin	nore
-	Funeral		Social Security Number 6. 8	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Count	ace (State or Foreign
н	Director		220-34-3646	¹ X ^{M 2□ F} 6	9 Yrs.	Months Days	Tiouis Willi.	5-8-1			
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	100.	. City, Town or Lo	cation				10	0d. Inside City Limits
	a-f sh	ctor	Md. Baltim	ore	Wood]	awn					Y∏Yes 2 ☐ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	al Director	10e. Street and Number 2020 Featherbe	ed Lane Ap	t. 232	10f. Zip Code 21207	7	1	•	n of What Coun SA	ry?
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14	Race - America Black, White, 6	
336	urs afte	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		s	pecify: B	lack
21215-0036	72 ho natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of wor	king	16b. Kind	of Business/Ind	ustry
121	within ene. than "	jdw	Elementary/Secondary (0-12) 10th grade	College (1-4or 5+)	I	DO NOT use retired, nauffeur) "		Bal	timore	City
d 2	Hygin other ent, th	Be Co	17. Father's Name (First, Middle, Las)		Idazzeaz	18. Mother's Nam	ne (First, Middle,			- 1
/lan	Mental Mental arked o	To B	Willie	G	Graves		Call	lir		Buckson	
Maryland	2 should and Men is marke raumatic	i	19a. Informant's Name/Relationship			ng Address <i>(Street a</i> D5 Lochnet					,
	1 and Health		Jolene Dowtin 20a. Method of Disposition	Daughter 20	b. Place of Dispo	sition (Name of	T	Date		ation - City or To	
ē	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	Removal from State	Cemetery, crea	matory or other place ne Cem.	^{e)} 6–30	0-07		imore,	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lice		M a	2. Name and Addres	s of Facility West	,			
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	aplications that caused the co	death. Do not ent	300 Waba ter the mode of dying	sh_Ave, g, such as cardiac	Balti or respiratory ari	more est,	Md_	21215 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	1.6+11	in CAT	1Com	Ans.	. 100	2 - 1	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	Te CIT) (Cecora	y ricery	PISC	(050)	
į,	Exammer	<u>.</u>	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to (or as a con	rsezuezare ultr						
./	ute d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		ocquentee ory.						
ó	tificate be execute g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of):						
68760,	cate be	edical		▲d							
		/Me	IF FEMALE:	23c. If yes, outcome pf pre	egnancy				23	d. Date of delive	an.
. Box	death cert e attending d for use a	sician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ ☐ 4 ☐ Pregnant at time	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			20		Day Year
P.0	at the I by the	Phys	9 Unknown	9□ Unknown							
Records,	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.			No 3 Prob	ne cause of death? ably 4 Dunknown
eco	has bee	Completed						24a. Was a	sy	prior to cor	psy findings available npletion of cause of
<u>=</u>								1□ Yes	med2. 2 No	death? 1 ☐ Yes	2 No
Vita	hysiclan: nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Othe	ar.	ath <i>(Check only or</i> forme 52 Resid		□045-s (\$===if)
סר	ding Phy n. After this funeral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o		/ at	28d. Describe h			<u>"</u>
Sior	Attending Physician: r death. ector: After this certific. by the funeral director.	atio	Natural 5 Pending investigation 3 Suicide 6 Could not to	n	injury		Yes 2 □ No		_		
Division or	P S F P	Certification:	3 ☐ Suicide 6 ☐ Could not be determined			reet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, deat mination and/or ir	th occurred at the tin	ne, date and place pinion, death occu	e, and due to the curred at the time,	cause(s) a date and p	and manner as si place, and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	>		29c. License	number		29d. Date	signed (Month,	Day, Year)
)	0			1.		Mas	6775		10-	26-0	
	4		30. Name and address of person, who	completed cause of death	(Item 23a) (Type,	Print)	2120	u(S	irte.	208)	
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Tegistrar's S	Signature	reste	,				
		٠.,		A Paris	- 6						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 26, 2007 GENE W. GIBSON JUNE 8:00 P. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 8333 RIDGELY OAK ROAD PARKVILLE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 219-44-9740 61 2/4/1946 WEST VIRGINIA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Director BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8333 RIDGELY OAK ROAD 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Date V: IETNAM 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SUNPAPER 12TH GRADE DISPATCHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN R. GIBSON ၉ MARTHA SUE HUFFMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health ant; If item 27 ls JUDY A. GIBSON/WIFE 8333 RIDGELY OAK ROAD BALTIMORE, MD of Disposition (Name of Date 20c. Location - City 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VET. 7/2/2007 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any injury or o once. N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TOWSON, MD Immediate Cause (Final Physician months disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director:

3altimore, Maryland 21215-0036

Medical

Certification:

State Registrar

24

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1-127107 34 531

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4136 B E. Joppa Boad Perry Hall, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

6 Could not be determined

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 318SON, ROBER after death. 6 To the Hospital or within 24 hours at To the Funeral D

with the Maryland

death

filed within 72 hours after

than

al Hygie

ould be f is marked o

Pages 1 and 2 should nent of Health and Men

and

ed by the attending physician detached for use as the buria

the

Maryland 21215-0036

Baltimore,

28a-f show

an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at

Certification: 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 20656 TOOS, ES ZUNT

State Registrar

filled in by the funeral

KOUSTANTIN ZUBELEVITSKLY 900 CATON AVE, BALTIMORE, MD 21829 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



acqueline Green	· · · · · · · · · · · · · · · · · · ·	rtment of Health and Mental H		02							
Physician	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 3. Time of Death	th							
ledical Examine		REEN	June 25, 2007								
	Facility Name (if not institution, give street and number) John Hopkins Bayview Medical Center	4b. City, Town, or Location of Death Baltimore	N/A								
Funeral	Social Security Number	ast birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or								
Director	099 46 8642 1 M 2 XF 49	Yrs. Months Days Hours Min	Mar.6,1958 CANTOLINA	MD							
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent	Town or Location	10d. Inside City	v Limits							
ow any	MD N/A	BALTIMORE	1X Yes 2	·							
the Maryland a or 28a-f show lifted at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygieva and Waterland Type and Transmite event, the Medical Examiner must be notified at once. To Be Commissed by Enmeral Director	5531 Whitby Rd.	21206	USA								
or items 23	11. Marital Status 12. Was Decedent Ever in U.S 13. Never Married 2. Married Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S		ck,							
or ite	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	1 Yes 2X No specify:									
urs'afte		16a. Decedent's Usual Occupation (Give kind of	SpecifyBLACK work done 16b. Kind of Business/Industry								
5-0036 ed within 72 hour lygiene. other than "natte he Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti									
036 vithin ene. er that	12TH	SCHOOL									
15-C		e (First, Middle, Maiden Surname) DELL PITTMAN									
21215-0036 bould be filed within 7 d Mental Hygiene. Is marked other than ite event, the Medica To Be Commits	MORRIS GREEN 19a. Informant's Name/Relationship (Type, Print.)	Rural Route Number, City or Town, State, Zip Code)									
MD d 2 sho lith and in 27 is aumatis	ANITRA L. GREEN										
re, l		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State								
imo Pages nent o nent o	4 Donation 5 Other Specify: OAI	KLAWN CEMETERY JUN	IE 30,2 <mark>007 BALTIMORE,M</mark>	iD.							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygion. Important: If fiem 27 Is marked other than " injury or other traumatic event, the Medical To Be Commission	21 Sgnature of Funeral Service License	22. Name and Address of Facility CALVIN B. SCRUG	GS FUNERAL HOME								
Physician	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac	ST BALTO MD 21213 or respiratory arrest, shock, or heart Approximate	Interval							
/Medical	failure. List only one cause on each line.	nerosclerotic cardiovascular	Between Ons								
taminer	or condition resulting in death) Due to (or as a consequence of		4.65								
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	cause. Enter Underlying Cause (Disease or injury that initiated										
My ansit):									
be executed rician and ricial - transit		7/2/07 TT // 23a,27,perMF,g8	(0. 7/10/07 77								
	IF FEMALE: 23b. Was decedent pregnant in the	,									
Box 68760 Geath certificate the attending physical for use as the business of the attending physical for use as the business of the attending physical for use as the business of the attending physical for use as the business of the attending physical for use as the business of the attending physical for use as the business of the attending physical for use at the physical for use as the business of the attending physical for use as the business of the attending physical for use at the p	past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregnath 5 Other (Specify)	ancy Month Day Ye	ear							
D. Boy t the death by the att	1 Yes 2 No 9 V Unknown g Unknown	o one (open)									
ires that the displaying signed by the detached		esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de								
ords, I			24a. Was an 24b. Were autopsy findings a								
Records, The law requires fificate has been sig			autopsy prior to completion of ca performed? death?								
Vital Rec ysician: The his certificate director, page		26.Place of Death (Check	1 Yes 2 No 1 Yes 2 only one)	No							
of Vital ng Physician After this certi	examiner?	Othor	ng Home 5 Residence 6 Other:								
ing Ph		28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
ivision or Attend after death. Director: I in by the f	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		0:1							
Division ospital or Attending tours after death. Ineral Director: After filled in by the function of the function.	3 Suicide 6 Could not be determined (Specify)	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Numb or Town, State)	ber, City							
Hospit Hospit Funera ely fill		ge, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated.								
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours afferd death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the building completely filled in by the funeral director, page 2 should be detached for use as the building the certification.	one) 2 Medical Examiner: On the basis of examination are and manner stated.	-	at the time, date and place, and due to the cause(s)								
F % F 8	29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
	Totale Tollelan	O.C.M.E.	June 26, 2007								
Ø	30. Name and address of person who completed cause of death (Item Patricia Aronica-Pollak MD. Assistant Medical E		re. MD 21201								
χι Stat	Too Secretary Street										
Ponistro	11IN 9 9 2007 Region A.	ILANASTA I									

DHMH 17 Rev 1/2001 OCME 2006

			1 For State	State of Ma	-	epartr	ment of H	ealth a		-			01007
			Registrar			Certifi	icate of L	Death			Rag. No.	U V /	2.02/
	Physici		1. Decedent's Name (First, Middle, Last	$^{"}\mathcal{W}$	Gard	lner			2	Date of De	Day 26	2007	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give	_		4b	. City, Town, or				4c. C	ounty of Death	
d	A. Ed		Wilson Hearth Can		// / / /		Sathe Under 1 Year	rs low If Under 2		Data of Bio		Monta	
	Funeral Director		5. Social Security Number 6. Se 186-20-4880	TM 2027 €	(In yrs. last birt		onths Days	Hours	Min	Date of Bir (Month, Da arch 14	y, Year) • 1921	Penn	place (Shte or Foreign intry) sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on						10d. Inside City Limits
	Maryl a-f eho	tor	Maryland Montgome	ry	Bethes	da							1 ☐ Yes 2🛣 No
	or 284	Funeral Director	10e. Street and Number				Of, Zip Code				-	of What Cou	•
	eath v	erai	5906 Lone Oak Driv	12. Was Decedent E	ver in U.S.		20814	spanic Orio	nin? (Specif			I. Race - Amer	
39	d within 72 hours after death with the Maryland piene. Ir then "naturel", or Iteme 23a or 28a-f ehow In Medical Exactinational be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:			Decedent of Hiss, specify Cubar Yes 2 \ No	Specify:	, Puerto Rio	can, etc.)	i	Bleck, White	
2-0	72 hou natura	eted	15. Decedent's Edu (Specify only highest grad		16a.	(Give kind	's Usual Occupa d of work done d	lurina most	of working		16b. Kind	of Business/li	ndustry
21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) He	`lite. DO l omema	NOT use retired))			Own	Home	
d 2	be filed within tal Hygiene. Id other than event, In a Me	Be Co	17. Father's Name (First, Middle, Last)							First, Middle			
Maryland	2 should be and Menta is marked is umatic ev	10 E	Henry Wachter							Beatri			
	ges 1 and 2 should be filed nt of Health and Mental Hyg : if item 27 is marked othe or other traumatic event,		19a. Informant's Name/Relationship (T) Susan N. Gardner			•	^{ddress (Street} a ne Oak						
Baltimore,	jes 1 and 2 of Health if item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of cemeter	Disposition y, cremato	n (Name of bry or other place	e) Ji	me 29,	2007	20c. Loc	ation - City or 1	own, State
Ħ,	t. Partmer		4 Donation 5 Other Specify 21. Signature of Funeral Porrise Lice)	Montgome	-	matorium,	Inc.					aryland
Ba	Depariment Deparement of the police of the p) XCOK	2	M00896	300	w. Mont	gomer	ry Ave	e., Ro	ckvil	lle, Inc le, MD	20850
7			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused ine cause on each line	the death. Dor	not enter th	ne mode of dying	g, such as	cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death
To desire	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	of):	ments	ά					
Sec.	Examiner	Ę	Sequentially list conditions,	b		0							
1	ursit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	Of):							
,760,	cate be executed physicien and the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):							
6876	icate b physic s the bi	dical		d.									
Box (death certifica e attending ph d for use as th	an/Me	230. was decedent pregnant	23c. If yes, outcome o		3∏Ect	opic pregnancy				23	3d. Date of deli	
O. B	thet the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□ Pregnant at t 9□ Unknown			her (specify)					Month	Day Year
<u>α</u>	es thet tigned by	by Ph	Part II. Other significant conditions co	ntnbuting to death bu	t not resulting in	the under	rlying cause give	n in Part I.		23e. Did 1	tobacco us	e contribute to	the cause of death?
ord	w require been sig should b	ted							_	1 🗆	Yes 2□	No 3□Pro	bably 4 ⊠Unknown
Records,	e la has	Completed		·····					or name and a final date of	24a. Was auto perfe		prior to death?	topsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical					26 Place	of Death /	1 ☐ Yes Check only		1 🗆 Yes	2 No
of Vi	S 0	To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2□ER/Ou	tpatient 3	3 DOA Othe	vr (Other (Spec	eify)
o uc			27. Lanner Death 1 de ural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. T	rime of njury	28c. Injury Work	raf c? Yes 2 □ I		d. Describe	how injury	occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, fa			163 201				Number or Ru	ral Route Number,
Ö	irs after rel Dire			building, etc.							wn, State)		
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Phy (2 Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination and	dor investi	curred at the tim igation, in my op	ie, date an pinion, dea	d place, and th occurred	d due to the at the time,	date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier				29c. License	number			-	signed (Monti	
	1.		30. Name and address of person who c	omniated cause of do	-	Type Prin	200	1574	23		Ju	e 27	2007
_	Μ.			201 Rus	1 4	e G		burg	ND	20	877		
ST 2	Sta Registr	1	31. Date filed (Month, Day, Year)	22. Registra	r's Signature	ball)				
1			JUN 2 9 2007	TO COUNTY	~ /								

DHMH 17 Rev 1/2001

			For State of Maryla 1 - State Registrar		artment of H rtificate of I			giene Reg. No. 🤈 🏻	חיז	21022
	n - m + 4	15	Hegistrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Joseph H. Hick				June J	Day 27. 200	Year 7	11:30a ^M
į.	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	- Juite-	4c. County	of Death	
			2514 Londonderry Rd.			monium			timor	
Ţ.	Funeral			rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v, Year)	9. Birth Coມ	place (State or Foreign intry)
S.	Director		212-05-5812 1X M 2 F 97 Usual Residence of Decedent	113.			June 2	5,1910	Md.	
	land ow			City, Town or Lo	cation					10d. Inside City Limits
	Many a-f sh	햣	Md. Baltimore	Timoniur	n					1 □Yes No
	or 28¢	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cou	intry?
	23a c ust b	al	2514 Londonderry Rd.		21	093		USA		
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Amer ck, White	ican Indian, , etc.
36	rs afte	by F	1 ☐ Never Married 2 【X Married I ☐ Yes 2 【X No I If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1□Yes 2XNo	Specify:		Specil	v: Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hyer than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of B	usiness/I	ndustry
215	hin 73 9. an "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ring			
	filed with Hygiene other the sent, the	Completed	12 yrs.	Eng	ineer			BGE		
2	e d al	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			me)	
<u> </u>		2	Henry Hick				Karvace			
Maryland	12 s h ar 7 is trau		19a. Informant's Name/Relationship (Type. Print) Ronald Hick son		ng Address (Street Londond				. ,	' '
<u>ē</u>	of Health Item 27 other tr	,	20a. Method of Disposition 20	b. Place of Dispo	osition (Name of matory or other place	(e) July	Date	20c. Location	- City or T	Town, State
E 0			1 💢 Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Holy Rec	deemer		007	Baltin	ore	
Baltimore,	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Licenses		2. Name and Addre	ss of Facility		S 3 - 31-		
m —	89 = 88		King mes f		onnelly F 110 Solle	rs Point	Rd. 21:	222		
П			23a. Part. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line	leath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dehyo	tvato	W				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a con-	sequence of)!						
*		Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):						class
·-	nted Insit	Examiner	Cause (Disease or injury	auno	v.i.a					washe
o,	execuin and ial-tra		that initiated events c. Due to (or asia con:		7-7-0-					
58760,	icate be executed physician and s the burial-transit	edical								
			IF FEMALE:							
. Box	death certific attending pl	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	⊒Ectopic pregnanc;	y			ate of deli onth	very Day Year
o Ö	ne deg the al	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)			"	OTTET	Duy Tour
<u>o</u> .	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giv	ren in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of death?
Vital Records,	signe d be	d by			, ,		1 🗆	Yes 2 No	3 ☐ Pro	obably 4 Unknown
Ö	w req	ete					24a. Was	an 24h	Were au	topsy findings available
Ä	he lav e has age 2	Completed					auto perfo	psy ormed?	prior to death?	completion of cause of
ā	an: T tificat or, pe		25. Was case referred to medical			26. Place of Dea	1 Yes	2 No	1 □ Yes	2□ No
>	Physician: The k r this certificate ha ral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient :	2 ☐ ER/Outpatier	nt 3 DOA Oth	or:	ome 5 ∑ Resi		her (Spec	eify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Inju- Wor			how injury occu		
<u>S</u>	endlr sath. or: Al	atic	2 Accident investigation			Yes 2 No				
Division or	l or Attendafter death	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - A building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Ru	ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ပ္ပ	29a. Certifier **Certifying Physician: To the best of my	knowledge, deat	th occurred at the ti	me, date and place	and due to the	cause(s) and r	nanner as	stated
	To the Hospital within 24 hours в To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	1.00	29c Licens	se number		29d. Date sign	ed (Monti	h, Day, Year)
			() as Thene	lina M.	(D)	17/18		June	281	2007
	1 ^		80. Name and address of person who completed cause of death (, Print)	101	7/-			
	U		Tanl Schwartz MD.	3512	Newla	nd fel	212	(F		
	Sta Regist		31. Date filed (Month, Day, Year)	il indicators	ARL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June **Physician** 19:00 Elaine Hughes 23 2007 /Medical 4a. Facility Name (If not igstitution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Mayland Medical Baltmon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Humber 6. **6**ex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 026-28-7957 70 Director Dec.17,1936 MA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Ves 2 No DE Kent Dover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 E. Division Street 19901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 💥 ☐ No Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. Joseph Baron ပ Rhea Leah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Hughes, Son 124 Jennifer Lane, Felton, Delaware 19943 e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 06/29/2007 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambruso Funeral Director, Inc. 21. Signature of Fune al Service Licensee tuma 1175 State Street, Dover, DE 19901 M01113 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe sensis **Physician** 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of): tissue infection of arm Examiner NecroTizina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner signed by the attending physician and I be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 29b. Signature and title of certifier

ASSCF YOUSSU

Lousset 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

29c. License number

P17629

22 5 Greene Street,

29d. Date signed (Month, Day, Year)

June 23, 2007

Baltmoon, MD

and manner stated.

University of Mayland Medical Center

(ear) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

		4	For State Registrar	State of Maryland		irtmen <i>tificati</i>				giene Reg. No.) [21030
			Decedent's Name (First, Middle, Last)						2. Date of Dea	th	Vana	3. Time of Death
	Physicia		William Milton Hess	son					June 29	, 2007	Year	5:00 A.M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City,	Town, or	Location of Death		4c. County	of Death	
	Lxamiii	.	Carroll Hospice, Do	ove House		Wes	tmins	ster		Carr	011	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under Months		Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Cour	place (State or Foreign
	Director		220-28-9015	M 2□F 90	6 Yrs.				Jan. 28	, 1911	Mar	yland
7	2 .		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Lo	cation						I0d. Inside City Limits
	aryla shov	2		,								1XXYes 2 □ No
	89-f	ecto	Maryland Carroll	Mar	nchest	10f. Zip	Codo			10g. Citizen of	What Cour	ntry?
	or 2	ā	10e. Street and Number				102			United	State	
	s 234	eral	4609 Hanover Pike	2. Was Decedent Ever in U.S	. 13.1			spanic Origin? (Sp		of Amer	ce - Americ	can Indian,
30	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other then "natural", or items 23a or 28e-f show event, the Medical Exercities must be notified at	by Funeral Director	1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2XXNo If Yes, Give Year or Dates:		f Yes, spe 1 ☐ Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		ck, White, _{y:} Wh:	
9500-61212	72 hou	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece	dent's Usu kind of wo	al Occupa	tion uring most of work	ing	16b. Kind of B	lusiness/In	dustry
7	within 72 ene. then "nai he Medic	npie	Elementary/Secondary (0-12)	College (1-4or 5+)						~		
	e filed wall Hygier other the		8th		Del:	ivery	man	18. Mother's Nam		Greenmo	•	ruel
_	be fi	Be	17. Father's Name (First, Middle, Last)					Mary Eck			,	
<u> </u>	should be find Mental be marked of	2	Milton G. Hesson 19a. Informant's Name/Relationship (Typ)	o Printl	10h Mailie	an Addrass	/Street a	nd Number or Rur		or City or Town	State. Zii	n Code)
Na Na	12 she hand 7 ie mu				4609				ncheste			
യ്	s 1 and 2 should f Health and Men frem 27 ie marke other treumatic	1	Hilda Hesson (Wife 20a. Method of Disposition		ace of Dispo metery, crei				y 2,	20c. Location		
ဋ	Pages nent of int: If it	Н	Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State				!	-	Manchos	tor	Maryland
Baltimore,	artme ortan injury	1	21. Signature of Funeral Service License		Luthe			and the same of th			rer1	Hatytand
Ra	permit. Pages Department of I Important: If Its eny injury or or once.		I Hall Glado		Ec	ckhar 296 C	dt Fi harm	s of Facility uneral Ch il Drive:	napel, P Manch	A. ester	Marv	land 21102
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the duath.	Do not en	ter the mod	te of dyin	such as cardiac	or respiratory ar	rest,		Approximate
	nysician	W. I	Immediate Cause (Final disease or condition	Condi	100	(%)	Lul	Lites	Rich	tlon		nset and Death
	/Medical		resulting in death)	Due to (or as a consequent	ence ol):		000	00102)"	3		
	Examiner		Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	anaa al\:							
	ed sit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conseque	arica or).							
	al-trai	xar	that initiated events c. resulting in death) Last	Due to (or as a consequent	ence ol):							
8760,	ficate be executed physicien and s the burial-transit	dicai E	L _a									
	.≡ On a		Sh:									
ŏ	death certific e attending p id for use as	N/	IF FEMALE: 23b. Was decedent pregnant 23	ac. If yes, outcome of pregnan		DEctopic p	regnancy				ate of deliv	
.O. Box	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (s				I N	lonth	Day Year
о. О	at the	h.	9 Unknown					t. D. at	22a Did t	abassa usa sa	atabuta to	the cause of death?
<u>'</u>	8 5 9	þ	Part II. Other significant conditions con		Iting in the i	inderlying	cause give	en in Part I.	1, -111	Yes 2 No		bably 4 Unknown
or o	w requir been si should	ted	- Count C	emes								
Ö	law les b	Completed							24a. Was autoj			opsy lindings available ompletion of cause of
=		Co							1 ☐ Yes	2 No	1 ☐ Yes	2 No
₹ Z	ysiclan: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth	26. Place of Dea				Hos Dica
ō	Phys this al dir	2	1 ☐ Yes 2 No ''' 27. Manner ol Death	1 Inpatient 2 E	R/Outpatie 28b. Time o		UA	4 Nuising 11	ome 5 Resi	how injury occu		uty) DOSPICE
UC	ding Phy h. After thi funeral (ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	М	28c. Injun Worl 1 □	k? Yes 2 □ No		, ,		
Division of Vital Records,	l or Attending Physiclan: after death. Director: Atter this certifical in by the funeral director,	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho		reet, facto	ry, office				nber or Ru	ral Route Number,
2	5 # 5 E	Certification:	4 Homicide	building, etc. (Specity,)				City or To	wn, State)		
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) Certifying Phys	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, dea ion and/or in	th occurred evestigation	d at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	Within To th comp	Me	29b. Signature and the of certifier			29	c. Licens	e number		29d. Date sign	ned (Month	n. Dey, Year)
	01		10000	ON NO			Da	26116		6/29	101	_
6	, 4		30. Name and address of person who co	impleted cause of death (Item	23а) (Туре	, Print)			1 - 1 -	- 01	D.A.	Rocha
~	/			1000 4231 NOF	zthwa	ods T	Rail,	Hampstea	d, ma 21	074		N.D.
	St: Regist	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Signat	K	brack	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:30 a Gregory A. Howell Jun 19, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 2333 West Lexington Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**25**M 2□ F Maryland Director 217-66-4658 46 Jul 14, 1960 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Raltimore N/A Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A 2333 West Lexington Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 25 If Yes, Give Year or Dates: 250 No 1 Never Married 2 Married 1 ☐ Yes 2 XXVo Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schmidt Blue Ribbon Bread Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Howell Henry Howell မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2333 West Lexington Street Baltimore, Maryland 21223 Dollene Howell Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 □ Burial 2 □ Cremation 3 □ Removal from State Windsor Mill, Md. 06/25/05 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or her failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final disease or condition resulting in death) **Physician** Liver Failure weeks /Medical Due to (or as a consequence of): Hepatocellular Cancer months Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hepatitis C Infection Unknown Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **N**o 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 100 P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of

Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death. In the continual series of the series of the burial-transifilled in by the funeral director, page 2 should be detached for use as the burial-transif Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral L

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or :

Baltimore, Maryland 21215-0036

Examiner must be notified at

Certification:

27. Manner of Death

1 Death
2 Accident 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide More tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Austra Doyle, mo Greevelaum Caucer Ctr.,

32. Registrar's Signature 31. Date filed (Month, Day, Year)

uction



MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 23809

22 S. Greene St.,

29d. Date signed (Month, Day, Year)

MD

21201

Balt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23 Day Month 6 200^{Year} Physician Alfreda Harris 12:23pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore | Year | If Under 24 Hrs 609 N. Lakewood Avenue Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 □ XF 62 4-2-1945 Md Director 219-40-1809 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 X Yes 2 □ No Directo Baltimore Md. NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21205 609 N. Lakewood Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene. 7 is marked other than "natural", or items : traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cartwright Geneva ပ Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 Druid Street, Baltimore, Md. Health a Son Roland J. Fleming, Jr. Department of Health Important: If item 27 any injury or other tr once. 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-29-07 Dundalk, Md. Trinity Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Wane 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months onaestive **Physician** disease or condition resulting in death) /Medical Due to (or a s a onsequence of) Examiner iseas orunary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 mon 1 ☐ Yes 2 🗷 No 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After : (Month, Day Year, Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number PHYSICIAN DS 3590 2007 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 624 N BRO ADWAY BALTIMONE 21205 31. Date filed (Month, Day, Year) 32 Registrar's Signature State CORRECT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 147 **Physician** 24,200 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner MA If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖫 F -lock Director Usual Residence of Decedent 10d. Inside City Limits or Location 10a. State 10b. County 10c. City, Tow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Wes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Baltimore, Maryland 21215-0036 Specify. ş 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (f-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (A 20c. Location 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) 21. Signature of Funeral S attmore, md 21229 Balto. Nath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Predisease or condition resulting in death) Physician ntra Cerebra bleed /Medical Due to (or as a consequence of): Examiner untontrolle Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trail Due to (or as a consequence of): P.O. Box 68760, aftending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) s been signed by the sales should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Monknown cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 7 No director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA After this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: .
completely filled in by the f Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07 GUDURI Dr. to completed cause of death (Item 23a) (Type, Print) 30. Name and address of person y 40 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of W	arylario	-	tificate of		aria ivio		eg. Nó.	37	210	34
			Decedent's Name (First, Middle)	e, Last)					2	. Date of Deat	th		3. Time o	f Death
	ysici: Medic		Kiumars Irani						J	une 24	, 2007	Year	7:00	P. M
	camin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	r Location o	of Death		4c. County	of Death	1	
		ri	5 Orleans Terra	ice			Kensing				Montg	omery	У	
	eral ctor		5. Social Security Number 578–74–4080	6. Sex 7. A	ge (In yrs. Ia 62	s <i>t birthday):</i> Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, ec. 23,	Year) 1944	9. Birthi Cou Iran	place (State Intry)	or Foreign
Maryland	ifled at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omery		Town or Lo							10d. Inside C	City Limits 2 ⊊ No
vith the	pe not	Directo	10e. Street and Number				10f. Zip Code				0g. Citizen of \	Nhat Cou	intry?	
sath v	nust	eral	5 Orleans Terra	12. Was Decedent	Ever in II C	12.1	20895	lianania Ori	ain? (Pnesif		ran	o - Ameri	ican Indian,	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Items 23a or 28a-f show	event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ☒ Divorced	Armed Forces	?		Vas Decedent of H fYes, specify Cuba I∐Yes 2⊠ No	Specify:		can, etc.)	Blac	ck, White,	, etc.	
5-C 72 h "natu	dica	etec	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during mos	t of working		16b. Kind of B	usiness/In	ndustry	
121 within ene. than	₩ We	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	Arti		d)			Self E	mplos	veđ	
filed N	ent, tt	ပ္ထို	17. Father's Name (First, Middle,			212.01	- T	18. Mothe	er's Name (F	First, Middle, I	Maiden Surnan		,	
Maryland 2 nd 2 should be filed Ith and Mental Hygi 27 is marked other	ic eve	To Be	Nazer Irani					Tuba	Irani	Ĺ				
ary shou and M	umat		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural F	Route Number	, City or Town,	State, Zi	p Code)	
and 2	er tra		Irandokht Irani	/ Sister			eans Terr		Kensi	ington,	Maryl:	and 2	20895	
Baltimore, bermit. Pages 1 a Department of Hez Important: If Item	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other plac	ce) J	une 28	ŝ,	20c. Location -	City or T	own, State	
ti Pag tment tant:	luny		4 □ Donation 5 □ Other (S	pecify)			iemorial Pa		200		Rockvil			
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked	any ir		21. Signature of Funeral Service	Licensee	M0089		Name and Address							
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	d the death.	Do not ent	er the mode of dyin	ng, such as	cardiac or r	espiratory arre	est,		Approxima Interval Be	tween
Physic		i	Immediate Cause (Final disease or condition	Prob	ablo	371 C	vocard	la l	in	erc. 7	رهر	6	Onset and	Beath
/Med Exam			resulting in death)	Due lo (or as	a conseque	ence of): /		,)					
2		<u></u>	Sequentially list conditions,	b. Due to (or as	V	ρ						-		
rted	nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$ 200 10 (07 41)	, a conseque	31,00 01).								
exect	ial-tra	Examiner	resulting in death) Last	C. Due to (or as	a conseque	ence of):								
68760, filicate be execut	the burial-transit	ical		d										
C 68 ertifica ing ph	as th	Med	IF FEMALE:											
COrdS, P.O. BOX 68/60, A requires that the death certificate be executed been signed by the attending physician and	iched for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3□	Ectopic pregnancy Other <i>(specify)</i>	/				te of deliv	very Day	Year
s that ned b	e deta	by P	Part II. Other significant condition	ons contributing to death I	out not result	ting in the ur	derlying cause giv	en in Part I		23e. Did tob	oacco use cont	ribute to t	the cause of	death?
orduire quire	od blu								"	1 □ Y	es 2∐ No	3 ☐ Pro	bably 4 🛭	Unknown
VITAI KECOFIAS, P. sician: The law requires that certificate has been signed b	age 2 sho	Completed								24a. Was a autops perforr	med?	prior to co death?	opsy findings ompletion of	available cause of
	tor. p	BeC	25. Was case referred to medical					26. Place	of Death (1∐ Yes 2 Check only on		1 🗆 Yes	2□No	
Or VITA Physician:	director	2	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2∐E	R/Outpatien	t 3 DOA Oth	er: 4 ☐ Nu	ırsing Home	5 🖺 Reside	ence 6 🗆 Oth	ner (Speci	ify)	
	Ineral		27. Manner of Death Natural 5 ☐ Pendin	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Injur Wor	y at k?	280	d. Describe ho	ow injury occur	red		
VISION Attending r death.	the fu	cati	2 Accident investig 3 Suicide 6 Could i	gation				Yes 2□						
i te c	d in by	ertification:	4 ☐ Homicide determ	ined 28e. Place of III	jury - At hom tc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f	f. Location (St City or Town	reet and Numb n, State)	er or Run	ra <i>l R</i> oute Nur	nber,
To the Hospital or within 24 hours af To the Funeral D	etely fille	Medical C	29a. Certifier 1 Certifylr (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis and manners	of my know of examination	ledge, death on and/or in	occurred at the tir	me, date an opinion, dea	nd place, and ath occurred	d due to the call at the time, d	ause(s) and malate and place,	anner as s	stated. to the cause	(s)
Vithir th	сошр	Me	29b. Signature and title of certific				29c. Licens				9d. Date signe			
			1 gran 200	Joeck-	mo O	ME	D004	28		Jı	une 25,	200	7	
1			30. Name and address of person Ira N. Brecher,	·		, , , , ,	Print) cal Park	Drive	e, #30)4. Sil	ver Spi	ring.	, MD 2	0902
40	Sta	е	31. Date filed (Month, Day, Year)						-, ",	,, 0			, 12	
Re	gistra	ar	JUN 2 9	2007	rar's Signatu	190	MCL)							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	1 - State Registrar	State of Ma			cate of		•	Reg. No.	17		35	
	Physici	an	Decedent's Name (First, Middle, Las Allan David Jone						2. Date of De Month June		oYear of 7	3. Time of 4:13	Death P M	
	/Medic		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			ne 27, 2007				
	Examin	ler	1712 Beechwood Rd.				Es	sex		Baltimore				
	Director 210 40 2007						Inder 1 Year oths Days	oirth Day, Year) 17,1940 Maryland						
Maryland 21215-0036	land ow	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location	1	·				10d. Inside Ci	ty Limits	
	a-f sh		Maryland Baltimore Essex 1□Yes 2♥No									2 XNo		
	or 28	Dire	10e. Street and Number 1712 Beechwood Rd.				f. Zip Code 212	10g. Citizen of V USA	Vhat Cou	ntry?				
	eath v ns 23a must	eral				13. Was [pecify Yes or No					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			, specify Cub es 2⊠ No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		k, White, : Whi			
	72 hc "natu edical		15. Decedent's Education 16a. Decedent's Usual Occupation 16 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Bu	6b. Kind of Business/Industry				
	withir iene. than		Elementary/Secondary (0-12) College (1-4or 5+) 8 College (1-4or 5+) Merchandiser							Retail Store				
	al Hyg I other	BeC	17. Father's Name (First, Middle, Last)							, Maiden Surnam	ie)			
	lould b	Tol	Lewis Leo Jones		1			Ruth Ann						
	id 2 sh Ith and 27 is n traum		19a. Informant's Name/Relationship (7) James L. Jones (B)		I	_		and Number or Ru venue Not		-				
ore,	of Hea item		20a. Method of Disposition	D	20b. Place	of Disposition ery, cremator	(Name of y or other pla	ce)	Date	20c. Location -	City or T	own, State		
Baltimore,	Pages ment of h ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Morel	and Mei	morial	Park 6/3		Baltimo	re,	Maryla	nd	
Balt	permit Depart Import any Inj once.		21. Signature of Funeral Service Licen	VITRALIS	ko	140	/ Ola .	ss of Facility ki Funera Eastern <i>A</i>	avenue E	issex, Ma	aryla	and 212	221	
			23a. Part Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. ### APPROXIMATE APPROXIMATE TO SHOULD APPROXIMATE TO SHOULD APPROXIMATE INTERVAL APPROXIMATE I											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ble	H Cul	a My	o CARDIA	16 / Tota	ARC Two),			
	Examiner			b. #/>	AAD.	7112A	L 4	Went	Ser. Si	well				
	pi ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence	ence of):									
3.	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	e of):										
68760,	tificate be executed ig physician and as the burial-transit	edical E	Due to (or as a consequence of):											
	rtificat ng phy e as th		IE EEMALE:											
Division or Vital Records, P.O. Box	The law requires that the death cer tte has been signed by the attendir bage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						су			23d. Date of delivery Month Day Year		
	w requires that s been signed by should be deta	Tarti. Other significant containing to dealing at not resulting in the underlying cause given in part.												
	he faw rec has bee ge 2 shou	Be Completed							24a, Was auto perfe	psy	Were autorior to co	opsy findings ompletion of c	available ause of	
			25. Was case referred to medical					26. Place of Dea	1 Yes		I∐Yes	2□No		
	Physician: r this certificaral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier					lome 5 Na Residence 6 □ Other (Specify,			ify)		
	Jing P. After fune		27. Manner of Death 1 Natural 5 □ Pending	(Month, Day	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?			28d. Describe how injury occurred						
VISIO	Attenor r death ector:	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		M 1 ☐ Yes 2 ☐ No , factory, office 28f. Location (Street and Number or Fig. City or Town State)				er or Rur	ral Route Num	nber,			
Ď	ital or Irs afte Iral Dir Iled in	Cert	4 Homicide Building, etc. (Specify) City or Town, State)											
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifler (Check only one) Certifling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tated. Certifling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tated.										s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier				29c. Licens	29d. Date signed (Month, Day, Year)						
)			11				D14221				June 28, 2007			
	axl		30. Name and address of person who											
	Sta	ite	Dr. T. A. Firo 31. Date filed (Month, Day, Year)	32. Registra	223 Eas ar's Signature	stern A	Avenue	Baltimor	e, Mary	land 212	21			
	Registr		JUN 2 9 20	07 File Pera	15	Good								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	State of Mar	-	epartme <i>Certifica</i>				jiene eg. No.?	107	21035	
		Decedent's Name (First, Middle, Last)						2. Date of Death Month Day		Vaar	3. Time of Death	
Physici /Medi		Jesse	M ·	J8111	SOM			Tune	2614	2007	2.39AM	
Exami		4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital					Location of Death		4c. County of Death NA			
Funeral Director		5. Social Security Number 6. S	6. Sex 7. Age (In yrs. last birthda			er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-1-1924		9. Birthplace (State or Foreign Country) Va.		
ъ		Usual Residence of Decedent			or Location					1	0d. Inside City Limits	
arylar show	7	Tod. State									1 X Yes 2 □ No	
the M 28a-f notifie	recti	10e. Street and Number			10f. Zip Code			1	10g. Citizen o	of What Coun	itry?	_
3a or	E D	5507 Mayview Ave.				21206						
darfer death with the Maryland after death with the Maryland or items 23a or 28a-f show miner must be notifited at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dec	edent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,		
s after , or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:						city: B]	lack	
within 72 hours af within 72 hours af ene. than "natural", or the Medical Exam	ed b	15 Decedent's Education 16a, Decedent's Usu							16b. Kind of Business/Industry			
r 10.	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of worki life. DO NOT use retired)			king Cha			The - I Cour	
A L	Completed	8th grade		<u> </u>	Pipe F	itter					Steel Corp.	· —
land Id be file lental Hy Ked oth Ic event	To Be (17. Father's Name (First, Middle, Last) Jesse John			son				e (First, Middle, Maiden Surname) Le Underwood			
ire, IMaryland ZIZIO-UU30 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Redina J. Molock		19b.	Mailing Addre	ss (Street a	and Number or Rui	al Route Numbe	er, City or Tov	wn, State, Zip 2120		
tem 2		20a. Method of Disposition			Disposition (N y, crematory o			Date		on - City or To	own, State	_
baltimor permit. Pages Department of i Important; if its any injury or o once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			Grove		1	9-07	Good	chland	, Va.	
Salti sermit. Separtm mporta iny Inju		21. gnatur of Funeral Service Lice	70 71/1L		22. Name	and Addres	ss of Facility	March E	F.H. Ea	ast	21202	
D 99 E 8 9		perent to	2. Walte	rap			North Av			, MO.	21202	
Physician /Medical		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Impedit to Cause (Final disease) or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Class Moor Constitution or condition resulting in death)										-
Examiner		Sequentially list conditions, if any, leading to immediate	b. Due to (b) as a	consequence of	of):							
cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Dia	liele	8							
cate be executed physician and the burial-transit in the burial-transit	Ä	resulting in death) Last	consequence of	Reval faile			inf.					
cate be ex physician the burial	dical		_d. 600 60	THE.	X	90 2	gain	NCC				_
de ath certiff e ttencing d or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	lecedent pregnant past 12 months? es 2 \[\int \] No 1 \[\int \] Live birth 2 \[2 \] Fetal death 3 \[\int \] Ectopic pregnancy 4 \[\int \] Pregnant at time of death 5 \[\int \] Other (specify) \[\limits \]						23d.	23d. Date of delivery Month Day Year		
hat i		Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying	g cause give	en in Part I.	23e. Did to	obacco use o	contribute to t	he cause of death?	ī
Hecords, he law requires t e has been signe age 2 should be o	d by							1 Yes 2 No 3 Probably 4 Unknown				
aw rec	Completed							24a. Was		4b. Were auto	opsy findings available empletion of cause of	
VITAL HER siclan: The lav certificate has irector, page 2.3	mo							perfo 1 Yes	rmed? 2 No	death? 1 ☐ Yes	2X No	
Vital siclan: T certificat rector, pa	Be	25. Was case referred to medical examiner?				Leu	26. Place of Dea	th (Check only o	ne)			_
Or V Physic this or	2	1 ☐ Yes 2 MiNo Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing						Home 5 Residence 6 Other (Specify)				
ding F	ioi	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Tim (Month, Day Year)				of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred				
DIVISION OF I or Attending Phy after death. Director: After this	Certification:	 2 Accident 3 Suicide 4 Homicide 4 Gould not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify) 							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce											
thin 2 the 3 the 3	Med	one) 29b. Signature and title of certifier	and manner stat	tea.	- 1	29c. Licens	se number		29d. Date si	igned (Month	, Day, Year)	_
<u> </u>		Shreigh Imperacun' D 30661					1 June 26th 200/					
6		29b. Signature and title of certifier D30.661 June 26th 2007 30. Name/and address of person who completed classe of death (Item 23a) (Type, Print) S60 Loch Kaven Byra. Baltimal - Kd - 21237-										
S	tate	31. Date filed (Month, Day, Year)	1007 Registra	r's Signature	done	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	-	artment of He <i>rtificate of L</i>			giene Reg. No. 🔃 🗍	107	21037						
	Physici /Medio		1. Decedent's Name (First, Middle,		h Jame	es		2. Date of De Month	Day	Year	3. Time of Death 838 A M						
	Examin Funeral Director		4a. Facility Name (If not institution, some security Number 247-72-0860	give street and number) Lal of Baltin	rs. last birthday) 63	4b. City, Town, or Balfin	Location of Dea Location of Dea Locati	th S. Date of Bir (Month, Da	rth ay, Year)	9. Birthpl Count	N/A lace (State or Foreign						
	D .	-	Usual Residence of Decedent					Ар	r 7, 1944		So. Carolina						
	arylar show	7	10a. State 10b. County		City, Town or Lo					10	0d. Inside City Limits 1 □ Yes 2 □ No						
	the M 28a-f	Director	Maryland 10e. Street and Number	N/A		10f. Zip Code	Baltimore		10g. Citizen of	What Coun							
	death with the Maryland ms 23a or 28a-f show r must be notified at	i Di	2500 West Belvede	re Ave.		Ton Zip Godo	21215		.09. 012011 01	U.S							
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cuba			o- 14. Ra	ce - America	an Indian,						
iah James Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Novever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☐ N	Specify:	nto Hican, etc.)	Speci	ack, White, e	etc. Black						
4 P	72 ho natur licai E	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind of I	Business/Ind	iustry						
1215	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)) "	5		Private (Company						
2 2	led w lygier her th		12	4)		Constru	action Worl		1		Jonipariy						
J. and	I be find the find th	Be	17. Father's Name (First, Middle, La	'illie James			18. Mother's Na	ame (First, Middle	Bakir Sve	,							
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	12 should be filed within 'n and Mental Hygiene.' 7 is marked other than "r traumatic event, <u>the Mec</u>	은	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	and Number or F	Rural Route Numb			Code)						
Ma	and 2 sealth ar		Cathy Miller-Cheek			3706 Brice Ru					,						
هُـــُ. ق.	s 1 al of Hea ftern othe		20a. Method of Disposition	200		osition (Name of matory or other place		Date	20c. Location								
E L	Pages nent of int: If it		1 ☐ Burial 2 ☐ Oxemation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State		etro Crematory	1	06/29/0	7 Ca	atonsville	, Maryland						
Ell	permit. Departn Importa any inju		21. Signature of Funeral Service Li	1 1/4 (1	2	2. Name and Addres	s of Facility				,,						
_	90 E # 9		Loud	Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Sa. Part Fetter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between													
			Shock, of heart takere. List only one cause on each line.														
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a C O F	P						10 Years						
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):												
3	# V	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	equence of):					-							
5 J	uted I ansit	Examiner	Cause (Disease or injury that initiated events														
CACWA O,	be executed ician and burial-transit	Еха	resulting in death) Last	c Due to (or as a cons	equence of):												
nt kn 68760,	icate be executed physician and s the burial-transit	edical		d													
2 89		Medi	IF FEMALE:														
letie Box	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1□Live birth 2□F	etal death 3[⊒Ectopic pregnancy				ate of delive	ery Day Year						
0	he des	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5[Other (specify)		-	"	nontil	Day rear						
ص.	that the sed by detact	Ph	Part II. Other significant condition	s contributing to death but not r	resulting in the u	ınderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?						
ds,	sign sign	d by	Respirator	y failure	ŭ	, ,		1 1 -	Yes 2 No	3 ⊅ Prob	oably 4 □Unknown						
o o	law req as beer 2 shou	ete	coronary	artery a	licelos	0		24a. Was	an 24h	Were auto	psy findings available						
æ	The la e has age 2	Completed		_ correctly at	n (ac)			auto perf	ormed?	prior to cor death?	mpletion of cause of						
ta	an: T	Be C	25. Was case referred to medical				26. Place of De	ath (Check only	2 T No	1 ☐ Yes	2 (No						
>	nysici nis cel direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Othe	er: 4 🗆 Nursing	Home 5□Res	idence 6 🗆 O	ther (Specify							
0 U	ng Pł fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o	of 28c. Injury Work			how injury occu								
sio	eath. or: A	atic	2 ☐ Accident investigat	tion			Yes 2 □ No										
Division or Vital Records,	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin		t home, farm, st ec <i>ify)</i>	reet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rura	al Route Number,						
	pitai ours a erai [29a. Certifier 1 Certifying	Physician: To the best of my k	(nowledge deal	th occurred at the tim	ne date and nice	ce and due to the	called(e) and	manner as at	tated						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Ex	caminer: On the basis of exam and manner stated.	ination and/or ir	nvestigation, in my o	pinion, death oc	curred at the time	, date and place	e, and due to	the cause(s)						
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sigr	ned (Month,	Day, Year)						
			De CI	En mo		194	78		Juno	27	200>						
	1.		30. Name and address of person w	·	tem 23a) (Type,		` '										
_	4		WEL XION	G MD P1 32. Registrar's Sig	K-D 2	Print)	4057:1	al of	Balti	mor	9						
	Sta Registr		31. Date filed (Month, Day, Year)		gnature	hack o	/	6									

Registrar

10

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donaldson

JUN 2 9 2007

31. Date filed (Month, Day, Year)

MD

32 Registrar's Signature

D0061677

3120 Erdman Avenue Balta MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #1, perMD, g868, 6/29/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:35™ Kye H. Lee-Kim 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PETHES DA, MARY CAND Monthometry SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 💢 F 93 14,1914 215-15-9432 April Korea Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he activity of the property. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2X No Bethesda Maryland Montgomery County Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 United States 9515 Edgeley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Specify: Korean þ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fabric and Textile Buisness Woman Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Soon Sun Kim Geun Yi-Kim ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 706 Nicholas Lane, Cockeysville, Maryland 21030 Catalina Park (Granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 13, 2007 Timonium, Maryland Dulaney Valley Mem. 4 □ Donation 5 □ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee er 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE CHOLANGITIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HOLANDIO CARCINOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-trar and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 mon 5 ☐ Other (specify) 4□Pregnant at time of death A Setached for law requires that the 9 ☐ Unknown been signed by Vital Records, P. 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 22/10 3 Probably 4 ☐Unknown 1 TYes B Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 No nhis certificate or Attending Physician; lec'h. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2/4/0 1 Inpatient 3□ DOA ို 1 ☐ Yes 2 ER/Outpatient Œ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier Mourisaus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

29

Kanduvelan Viswalingham 8600 Old Georgetown Road Bethesda, Md.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** Edward Norris Luckert 2007 1:40 A.M June 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Gilchrist Center Towson Baltimore County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) March 17,1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1MM 2□F 213-26-2645 80 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. N/A 1XXYes 2 □ No Maryland Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 2308 E. Cold Spring Lane 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Fire Department N/À 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milton Conrad Luckert Rose Wagner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Sandy Luckert (Daughter) 684 Budleigh Circle Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral ChapelJune 27,2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A et 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** en 4 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and bunal-trar Due to (or as a consequence of) Box 68760. Physician/Medical The law requires that the death certificate USB 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy perform certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ne 26, 2007 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON.MD. 21204 Charles St. 6601 Anthon N <11 Day, Year) UN 2 32 Registrar's Signature State 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 24, 2007 7:15 P M ESTHERLEE M. LlOYD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. | 3, 19 Baltimore Oak Crest Village Birthplace (State or Foreign Country) Ohio 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2X F 1923 83 295-18-0296 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland | Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21040 1910 Hawthorne Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie R. Double William Claude Derby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Lloyd-Crowley /Daughter 2504 Burgundy Drive, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Djsposition 1 Burial 2 Cremati 3 ☐Removal-from State Towson, Maryland 4 □ Do tion 5 □ Ot Hilltop Service Corp. 6-28-07 (Specify) 21. Sign e of Funeral McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) formorary Serie Due to (or as a consequence of): valus las Sequentially list conditions, if any, leading to inintegrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩6 24a. Was an performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a Date of Injury 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

burial-trai Box 68760. the attending pl been signed by the should be detached Vital Records, P.O. page 2 s Hospital or Attending Physician: ō Division

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

Completed by

Be

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Exa⊞iner must be notified at

nd Mental Hygiene. marked other than

ith and Mental h

Health a

permit. Pages 1 and Department of Healt important: If item 2 any injury or other once.

Physician

/Medical

Examiner

Examine

Physician/Medical

Completed by

Be

ဥ

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Medical Certification:

death with the Maryland

Baltimore, Maryland 21215-0036

To the 10

State Registrar

29c. License number 29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Parkuille MD 21234

28f. Location (Street and Number or Rural Route Number, City or Town, State)

M.O 00, - mon

1758646

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anna Monics 31. Date filed (Month, Day, Year) JUN 2 9 2007

5 Pending investigation

6 ☐ Could not be

determined

ualther 5800 Registrar's Signature

(Month, Day Year)

Boulevard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June 12, 2007 **Physician** 2:50 PM Robert Evans Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5125 Wickett Terrace Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1⊠M 2□F 64 Director 254-66-3272 May 12, 1943 Ĝeorgia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 21 No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 5125 Wickett Terrace United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1⊠Yes 2□No IfYes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. Elementary/Secondary (0-12) Unit Secretary Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Robert R. Long Grace Eugenia Manes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate Ann Bell / Partner 5125 Wickett Terrace, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, June 14, 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumpbrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of): **Examiner** End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Liver Transplant 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b irector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director: # 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled it 1 A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

5999 Burke Commons Road, Burke, VA 22015

29c. License number

0101233842

29d. Date signed (Month, Day, Year)

0

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

le of o

JUN 2 9 2007

Aklilu Yishak M.D.

31. Date filed (Month, Day, Year)

29b. Signature and

CLAIRA MAULISIBY

Division or Vital Records,

within 24 hours after death.

To the Funeral Director: completely filled in by the f the

DHMH 17 Rev 1/2001

Hospital

Medical

31. Date filed (Month, Day, Year) State JUN 29 Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

WARIA ROSAVES

Chloralis, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

2007



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P18614

29d. Date signed (Month, Day, Year)

JUNE 22, 2007

			For State Registrar	State of Ma	-	epartment of the Control of the Cont			eg. No.	1 21044						
4	Physici	an	1. Decedent's Name (First, Middle, La					Date of Deat Month	Day Year	3. Time of Death						
	/Medic	al	As Essilia Name //f act institution of		garet M		or Location of Death	J	un 21, 2007 4c. County of Dea	3:30 p M						
	Examin	er	4a. Facility Name (If not institution, gi	3 Maiden Choice	lane	45. Oity, Town,		more	ioi o danty oi o da							
	Funeral Director		5. Social Security Number 6. 214-40-7367		(In yrs. last birth	rday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Dec 29	9. Bir (Co.) 9, 1922	thplace (State or Foreign ountry) Maryland						
200	M M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits						
Man	a-f sh iffied	ctor	Maryland Ba	altimore			Baltimore			1 K es 2 No						
ith th	or 28	Director	10e. Street and Number			10f. Zip Code	0.000	1	0g. Citizen of What Co							
400	ns 23a must	Funeral	713 Maiden Choice La 11. Marital Status	ane 12. Was Decedent E	ver in U.S.	13. Was Decedent of	21228 Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	S.A. erican Indian,						
036	ral", or item	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ ৡc		Rićan, etc.)	Black, Whi	Black						
5	"natu	letec	15. Decedent's E (Specify only highest g	Education rade completed)	16a. I	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation e during most of work ed)	ing	16b. Kind of Business	/Industry						
121	permit. Fages 1 and 2 should be filed within 7 z hours arer death with fire maryland Department of Health and Mental Hygiene. Important: If firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM-dical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		Teacher		Baltimore Ci	ty Public School						
ם ק		Be C	17. Father's Name (First, Middle, Las	it)			18. Mother's Name									
ylar Silar		T0 E		nal Wilson					aret L. Wilson							
Mar	th and th and 17 Is m traum		19a. Informant's Name/Relationship Haywood Mayo Hust		19b.	Mailing Address (Stree	et and Number or Run Choice Lane B			Zip Code)						
ē,	of Heal		20a. Method of Disposition		20b. Place of	Disposition (Name of , crematory or other pla			20c. Location - City or	r Town, State						
imo	ment cant		1			n Forest Vetera		06/21/07	Owings	s Mills, Md.						
Baltimore, Maryland 21215-0036	Departr Importa any inj		21. Signa ure of Funeral Service Lice	111.20	Ten	22. Name and Addi Ester 1300	Brothers Fund Futaw Place B	eral Service, Saltimore, M	P. A. d 21217							
Œ			23a. Part. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sudden l												
	xaminer				a consequence of ${\sf ssive}\ \Gamma$	Dementia				5 years						
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	s consequence o											
68760,	physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. High B						10 years						
68760,	ician (al E		Due to (or as	a consequence o	ı <i>).</i>										
687	g phys	edical		d												
Records, P.O. Box		Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of de Month	elivery Day Year											
U .	ned by	y Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?						
ords	has been signed by the age 2 should be detached	ed b						1 🗆 Y	es 2 ∏1 10 3 □ F	Probably 4 Unknown						
ecc	as be	nplet						24a. Was a	sv brior to	autopsy findings available completion of cause of						
	certificate bector, page								2 ℃ 46 1 □ Ye							
Z K	secrif irectol	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	nt 2∏ER/Out	patient 3 DOA O	26. Place of Deat		<i>ence</i> 6 □Other (<i>Sp</i>	acity)						
OF	grinys ter this neral di	<u> - </u>	27. Manner of Death	28a. Date of Inju (Month, Da)	ry 28b. T	1			ow injury occurred	еспу)						
sior	or: Af	atio	1 Natural 5 □ Pending 2 □ Accident investigati 3 □ Suicide 6 □ Could not	on		M 1[☐Yes 2☐No									
Division or Vital Records,	after death. I Director; After d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, far c. (Specify)	m, street, factory, office	е	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,						
	To the Pospira or Autorining Priyacian. The within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination and											
ļ	within 24 i	Me	29b. Signature and title of certifier	ns			nse number	2	9d. Date signed (Mor	nth, Day, Year)						
1	2		30. Name and address of person wh 10755 Falls Ro			Type, Print) Luthervil	le,Md. 2	1093.	Dr. Dana	Franks						
þ	Sta		31. Date filed (Month, Day, Year)	1> .				,								
	Regist	ar	JUN 2 9	2007 Real	a B	freshi										

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** РМ June 25, 2007 3:23 Evelyn Green McCoy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase Manor Care-Chevy Chase If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 14, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2100 F Arkansas 1918 Director 429-26-4783 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County Show r 28a-f show notified at 1 No Yes 2 No Director None Washington D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or adical Examiner must be United States 20015 3737 Legation St., NW Apt. 204 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Art Center Senior Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lois Lucille McMath John Henry Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8502 Grubb Road, Chevy Chase, Maryland Meredith McCoy/ Daughter June 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Little Rock, Arkansas Roselawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01173 23a. Part1. Enter the disease, or a implication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer /Medical Due to (or as a consequence of): Total Organ Failure the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending properties for use as þ

Physician Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Physician/Medical Examine After Medical Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C	
IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Failure to Th	rive	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown
		Was an autopsy findings available prior to completion of cause of death? Yes 2X No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	cribe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - Actionie, fami, street, factory, office	tion (Street and Number or Rural Route Number, or Town, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, and due t niner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 Kaluan	K. W. D19609.	26 June 2007
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print) RAMAN R. T STOWN ROAD SUITE 202 GHITH	ULI. iERSBURG.MD20878

State Registrar

		4	1 - For Amend it	em 24a pe	of Mary	land / De	partmen 06/28 ertificat	707 d	lealth a hb Death	and N	lental Hyg	giene	007	21045
	Physici	an	1. Decedent's Name (First, Middl								2. Date of Dea Month	Day	Year	3. Time of Death
1	/Media	al	Robert C. McGo		umbor)		4h Cih	Town or	Location	of Dooth	June 18	_	nty of Death	8:40 AM
L.	Examin	er	100 Brightwood			06			ville				Ltimor	
	Funeral Director		5. Social Security Number 144-14-5994	6. Sex 1 M 2 □ F		yrs. last birtho	(ay) If Under	1 Year Days	If Under Hours		8. Date of Birth (Month, Day May 29	7	9. Birth	pplace (State or Foreign untry) W Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County	<u> </u>	100	c. City, Town o	r Location							10d. Inside City Limits
	Maryl	to	MD Balt:	imore		Luth	erville	2						1 ☐ Yes 2 No
	or 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen		untry?
	th wit	aiD	100 Brightwood	Club Dri	ve #20)6			210	93			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow simportant: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow simply injury or other treumatic event. I'm Mudical Examinat main be mutified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 1 Yes	2 🗌 No	in U.S.	13. Was Deced If Yes, spec 1 \(\sum \) Yes		ispanic Ori in, Mexicar Specify:		ecify Yes or No- Rican, etc.)	E	Black, White	rican Indian, e, etc. hite
ဝို	72 hou	Completed	15. Deceder (Specify only highe	it's Education	()	16a. D	ecedent's Usua	al Occupa	ation	t of work	rina	16b. Kind o	f Business/I	Industry unk
7	ithin 7	npie	Elementary/Secondary (0-12)	College	(1-4or 5+)		Give kind of wo fe. DO NOT u		•	_	9			
7	Hygier Hygier Sher th		12 17. Father's Name (First, Middle,	5+			busines	ss ex			e (First, Middle,	Maiden Sun	name)	
anc	d be find the cod of	Be c	Edward James 1								Schneide		ianie)	
Maryland 21215-0036	nd 2 should the and Me 27 is mark	ည	19a. Informant's Name/Relations Jean McGowan/	hip (Type, Print)		19b. N	tailing Address Bright	(Street	and Number	eror <i>Rui</i> b Dr	al Route Numbe	r, City or Too Luth	wn, State, Z ervil	Tip Code) 1e, MD 21093
Baltimore,	Pages 1 ar		20a. Method of Disposition 1		1	0b. Place of D cemetery,	isposition (Nar crematory or o	me of other plac	ca)		Date	20c. Locatio	on - City or 1	Town, State
Balti	permit. Departn Importe eny inju		21. Sur lun of Euneral Service Ronald	Licensee S. Wade	rirec		State Baltime		_		1 655 W.	Balti	more	Street
8760,	cate be executed with the purial-transit in burial-transit	Ical Examiner	Z3a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, pr heart failure. List only one cause en each line. Immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
P.O. Box 68	ath certifi ettending for use as	Physician/Medic										23d.	Date of deli	ivery Day Year
	w requires thet the de been signed by the s should be detached	۵	Part II. Other significant conditi	ons contributing to	death but no	ot resulting in th	ne underlying o	ause giv	en in Part I			bacco use d		the cause of death?
Il Records,	The law re- cete hes bee page 2 sho	Completed				····-		-			24a. Was autop perfo 1 Yes	rmed?	b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medica examiner?	Hospital:		1200		Oth	05		th (Check only o			
ō	Phys this ral dir	. To	1 Yes 2 No	16		2 ER/Outp		JA	4 🗆 NI	ursing H	ome 5 Residence 1			city)
o	th. After fune	tion	1 Natural 5 Pendir 2 Accident Investi	19	e of Injury onth, Day Ye	ar) Inju	iry M	28c. Injun Wor	k? Yes 2 □	No	204. 2000.00	.ov,a.y oo	0000	
Division of Vital	al or Attending s after death. ii Director: After id in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	200. Pla	ce of Injury - ding, etc. (S	At home, farm	, street, factor	y, office			28f. Location (S City or Tox		umber or Ru	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 12 Certifyii 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of m basis of exa inner stated.	y knowledge, o amination and/o	death occurred or investigation	at the tin	ne, date ar pinion, dea	nd place	, and due to the orred at the time,	cause(s) and date and pla	I manner as ce, and due	stated. to the cause(s)
)	To the To the comp	¥	29b. Signature and title of eartific	Vile	100	, ca,	290	730	e number			6/2	010-	h, Day, Year)
	10		30. Name and address of person	orter A.	use of death	(Item 23a) (T	ype, Print)	Cho	nles	St	Bal	It. My	213	204
	Sta Registi	_	31. Date filed (Month, Day, Year, JUN 2 8 200		Registrar's	Signature	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, Amend Item 27 State of Maryland (1) 23 (1) and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 7 7 **Physician** 6:03PM 2007 Edward C. Neary Jr. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 413 Joplin Street Baltimore 8. Date of Birth (Month, Day Year) 9. Birthplace (State or June 18, 1947 Mary land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2□ F 59 212-48-6112 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Medical Examiner must be notified</u> at Baltimore MD 1 XIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Joplin Street 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed disabled 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 sho Id be in Department of Health and 1 ental Important: If item 27 is marked o Edward C. Neary Sr. Genevieve M. Oberlander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Reed / sister 413 Joplin Street Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 6/21/07 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex or compl 23a. Part1. Enter the disease, or conshock, or heart failure. List only ations that caused (e d e cause on each it ... Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cance Physician 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No the 9□Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 1 🗀 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? (es 2 No certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

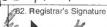
(3)

DHMH 17 Rev 1/2001

State Registrar

te 31. Date filed (Month, Day, Year) ar JUN 2 9 2007

30. Name and address of person who completed cause



ature Angelia

of death (Item 23a) (Type, Print)

Foster Avenue Balto, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph Pazdan Sr. 2007 2:45 a^M 26, June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9015 Carlisle Ave. Baltimore Nottingham If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 67 Director July 29,1939 Md 220-34-5721 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Nottingham permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21236 9015 Carlisle Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Storage Manager 12 yrs. 17. Father's Name (*First, Middle, Last*) 18. Mother's Name (First, Middle, Maiden Surname) Be Wanda Szymanski John Pazdan ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9015 Carlisle Ave. Nottingham Md. 21236 19a. Informant's Name/Relationship (Type. Print) Doris Kokta companion Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 30 St. Stanislaus Cem. Baltimore 2007 22. Name and Address of Facility 21. Signature of Juneral Service Licens Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** WEFTES /Medical Due to (or as a consequence of) **Examiner** Month (METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trer Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š MUGTUE PULMON ANY 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2K No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -21 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number LEDAKISMS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O PAUL PL. PAUTIMORE, MD 21202 227 55 MD ₩2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

JUN 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#26 per PHYS. G868 6/29/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month ear **Physician** 25, 4:30 P ^M 2007 June Stacy Roxanne Preston /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 103 Eastford Court Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Yrs. Director Jan. 10, 1966 Maryland 215-98-9007 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Baltimore Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 USA Items 23a 21234 72 Dendron Court Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Preston, Stacy Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: White 3 Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Heelih and Mental Hygiene. Importent: If Item 27 Ie marked other then "n eny injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Inventory Control Specialist Telecommunications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barbara Ann Howell Walter Winfield Preston ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 103 Eastford Court, Baltimore, Maryland 21234 Barbara Pino / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔯 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Grdn 6-30-07 Bel Air, Maryland McComas Funeral Home, P.A. 21. Signat 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 years Meta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Social tient list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attent 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown ete hes been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performe certificete 1 Yes 200 No 25. Was case referred to medical 26. Place of Death (Check only one) Be MODIEC S Other: 4 Nursing Home 55 Pesidence 6 NOther (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To this Atter thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 | Homicide within 24 hours e To the Funerel i to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120396 Jane 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hahr 5801

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2007

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #20a-b, perFH, g869, //2/0/ TT Certificate of D Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:30 PM WILLIAM 26 2007 JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner roup Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) Security Number **Funeral** Days 1**№**M 2□ F 218-46-6782 100 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show be notified at Battimore 1 res 2 No Director or 28a-f 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No | Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifq. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) nashoreman 18. Mother's Name (First, Middle, Maiden Surname) Be ပ injury or other traumatic 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or To Department of Health Important: If Item 27 I manue 20a. Method of Disposition
1 XBurial 2 Com 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetry cremetory or other place) 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5151 Balta Nath P. he Balt, merc, md 21229 em 2 7 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships or heart failure. List only one cause on each line. Immedi * Cause (Final diseas or condition resulting in death) **Physician** PNUEMONI 18 DAYS /Medical Due to (or as a consequence of): SYNDRUME **Examiner** DEFICIENC UNKNOWN ACQUIRED IMMUNO Supertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SUBSTANCE burial-tra Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ALNUTRITION 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ¼No 24a. Was an autopsy perform 1□ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. 1 23300 26 2007 JUNE 10 SELVURS 403P. BON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21223 13A 2TD PATE2 SUDHIR D 2000 W. BA2TO.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day June Marie Ruth June 24, 2007 9:20PM 4c. County of Death 4a. Facility Name_(If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, June 1, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Year) 21 214-18-9736 1 ☐ M 2 🔀 F 86 Yrs. Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Timonium 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2300 Dulaney Valley Rd. 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clifford Newman Mable C. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10275 Winged Elm Circle Manassas, VA 19a. Informant's Name/Relationship (Type. Print) 20110 VA Dolora Stoffa- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6/27/2007 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD New Cathedral Cemetery □ Donation 5 □ Other (Specify) 21. Signature of Furreral Service Licensee 22. Name and Address of Facility neral Chapel & Cremation Services X Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, r cor plications that caused the shock, or heart failure. List on cone cause on each line. eath. Do not enter the mode of dying, each as cardiac or respiratory arrest, 135272 immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

works.

, or items 23a or 28a-f

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If tiem 27 is marked other than "natural," or ite any Injury or other traumatic event, the Medical Examine any Injury or other traumatic event, the Medical Examine

Baltimore, Maryland 21215-0036

P.M.

9:20

24, 2007 ;, **P.O. Box 68760**,

JUNE 24

UNE RUTH
Division or Vital

the Medical Examiner must be notified at

Director

Funeral

ģ

Completed

Be

ည

Examine

Physician/Medical

ģ

Completed

Be (2

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and tit

and

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

3 State

Registrar

Part II. Other significant Conditions	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
Sacraf	Meer	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of	Death (Check only one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 DOA	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b	28e. Place of injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 50 9 M Margaret Rostenbach /Medical June 25, 2007 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death Examiner Manor Care Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 483.03.1134 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2 🕇 F 97 Director June 16, 1910 lowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or home any injury or other trainment. 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2 ☐ No Director Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Avenue 20817 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker mental health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Guy Bridgens Lona Gearhart ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James King P.O. Box 244 Tipton, Iowa 52772 Trustee 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/07/07 Rose Hill Cemetery Buffalo, Iowa 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOUS3 eart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Oronay /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4. Unknown 1 ☐ Yes 2∏ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registra

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) ALCK MATHUR 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 2 9 200



Physicies

DHMH 17 Rev 1/2001

29c. License number

10055694

Obey,

29d. Date signed (Month, Day, Year)

20832

26,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician NMA June 24 /Medical 4a. Facility Name (If not institution, give street and num 4c. County of Death 4b. City, Town, or Location of Death Examiner BaltimoreRehers Baltimore & Extended Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 1.17.1951 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**□** 1 2□ F 56 221.38.7012 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Dundalk Baltimore MD 1 ☐ Yes 2 ☐ 100 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 1736 Leslie Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Deces 2 | No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shop Owner Antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elane Townsend William Reiff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catharine Granger/daughter 1736 Leslie Rd. Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 06.26.07 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto. Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stas **Physician** /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas certificate has irector, page 2 2 ANo 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c funeral dire 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven mi 31. Date filed (Month, Day, Year) JUN 2 9 2007 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / [artment ortificate			nd Me		giene Reg. No.	007	21	054
	Physici	an	Decedent's Name (First, Middle, Las	it)						:	Date of Dea Month	ath Day	Year	3. Time	of Death
	/Media		Mary Jane Rinku								June	23,	2007	6:4	5 P ^M
4	Examir	ner	4a. Facility Name (If not institution, give		Tama		4b. City, To						County of Dea		
	Consent		Corsica Hills N 5. Social Security Number 6. Se		e (In yrs. last bir	rthdav)	Cent If Under 1		I I I I E		B. Date of Birt		Queen		or Foreign
	Funeral Director			□M 263 €		Yrs.	Months [Hours	Min.	B. Date of Birt (Month, Day Apr. 5			thplace (State ountry) 'yland	or r or orgin
	P.		Usual Residence of Decedent								.pr		10 11101		
	show	-	10a. State 10b. County		10c. City, Tow		cation							10d. Inside	City Limits s 2 No
	he M	Director	Maryland Queen Ar	ne's	Chest	er_	1 101 71 0					45 0'''		L	X-140
	a or 3	급	302 Skipper Lane				10f. Zip Ci						zen of What C	ountry ?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13.			anic Orig	in? (Spec	ifv Yes or No-		SA 14. Race - Am	erican Indian.	
ယ္	or iter	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 N				_		Puèrto R	ify Yes or No- ican, etc.)		Black, Whi		
8	72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show iteal Examilier must be notified at	d by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:			1□Yes 212	No I	Specify:				Specify:	White	
5-0	d within 72 hours after deeth with the Marylan jene. r than "natural", or items 23a or 28a-1 show the Medical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gradult)	ucation de completed)	16a.	(Give	dent's Usual (done dur	on ring most	of working	9	16b. Kii	nd of Business	/Industry	
121	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or 5	(+) C		<i>no not</i> use: ical	retired)				λα	countin	~	
d 2	il Hygid other ent,	e Co	17. Father's Name (First, Middle, Last)			TCT.	ICAI	18	8. Mother	's Name (First, Middle,			.9	
an	ould be Mental Marked o	To B	John Rinkus						Susa		ınk)		1- 11		
Maryland 21215-0036	P P P	-	19a. Informant's Name/Relationship (7	ype, Print)	19b	. Mailir	ng Address (S	itreet and	d Number	r or Rural	Route Numbe	or, City or	Town, State,	Zip Code)	
	1 and 2 Health a tem 27 is		Edward Rinkus / Br	other						heste	er, Mar	ylar	nd 2161	9	
altimore,	of Head of Head It item		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐	Removal from State	20b. Place of cemeter	f Dispo ry, crer	sition (Name natory or othe	of er place)		Da	te	20c. Lo	cation - City or	Town, State	
Ë	Pag tment tant: lury o		`4 □Donation 5 □Other (Specify)	Bayvie								imore,		and
Ball	permit. Pages 1 Department of H Important: If ite any Injury or ot 2005.		21. Signature of Fuperal Service Licen.	seed 1									al Home	•	
	497.60	\square	222 Part Poter the disease or com-	And	the death. Do								e, Mary	land 2	
			23a. Part1. Anter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	ne.					ardiac or	\	1651,		Interval B	etween
	Physician /Medical		disease or condition resulting in death)	a	1412		mus!	1 (-	56V	whe	h			2	15
	Examiner			Due to (or as	a consequence	oi).									
	4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à consequence	ofy.									
D.	acuted and transi	Examiner	that initiated events	c.											
8760,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):									
87	physicate by sine by the by	Physician/Medical		d											
9 X	ding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy								23d. Date of de	livery	
Вох	death e atten	clar	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death		Ectopic pregi Other (speci					-	Month	Day	Year
0	t the c by the ached	hysl	9 Unknown	9□ Unknown											
ď,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in	n the u	nderlying caus	se given	in Part I.		23e. Did to	bacco u	se contribute t	o the cause of	f death?
ord	equire en sig ould t										101	′es 2 \	3 No 3∏P	robably 4	Unknown
Vital Records,	has be	Completed									24a. Was autop	sy	prior to	utopsy finding completion of	s available cause of
<u>=</u>	The ate	Con									perfor 1 ☐ Yes	med?	death?		
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other:			Check only o	/			
ot	Phys r this ral dir	<u></u>	1 Yes 2 10	1 ☐ Inpatie		itpatien Time of		Injury at	STHOI		e 5 ☐ Resid ld. Describe h		Other (Spe	icify)	
O	Attending I r death. ector: After by the funer	tlon	1 Natural 5 Pending investigation	(Month, Day	Year)	njury	М	Work?	s 2 🗆 N			ov mjarj	, 55541154		
Division	I or Attendi after death. Director: A I in by the fu	ifica	3 Suicide 6 Could not be determined	286. Place of Inju		ırm, str	eet, factory, o	ffice	1511	28			d Number or R	ural Route Nu	mber,
Ö	tal or A s after at Directed in by	Certification:	4 Horriciae	building, etc	:. (Specity)						City or Tow	m, State)			
	To the Hospital or Attending Physiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 18 Certifying Phy 2 Medical Example 19	vsician: To the best of iner: On the basis of and manner sta	examination an	d/or inv	occurred at the stigation, in	the time, my opini	date and ion, death	place, an	d due to the d at the time, d	cause(s) date and	and manner a place, and du	s stated. e to the cause	(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifuer				29c. L	icense n		621		29d. Date	signed (Mon	th, Day, Year)	
İ	7.		191/19	nmn)						630		61	26/20	C '5	
	\		30. Name and address of person who co	D.11 00	> 11 1	do	Print) ()~	-(1,10	(!) . L.	(UN)	2/	G/9		
	Sta	tę	31. Date filed (Month, Day, Year)	32. Hogistra	ur's Signature	-	200			7-1 10	7. *	- (- /		
	Registr		JUN 2 9 2	007	that with	Jan B	SACI								

State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Amy Joyce Rutherford 5:45 P M June 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 230 Crocker Drive Bel Air
If Under 1 Year
Months Days Apt. \mathbf{F} 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Hours 217-58-9428 40 Director Oct 31, 1966 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ⊋No Directo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 USA 238 66 Sycamore Drive Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of ပ Claude Carlin Rutherford Betty Joyce Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar Important: If Item 27 is eny Injury or other trau Christian E. Townsley/Cousin 30 Cedar Valley Road, New Park PA 17352 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 06-29-07 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A., 1317 Cokesbury Road Abingdon, Maryland 21009 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one pause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** NOXI /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OC Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has birector, page 2 s 1 ☐ Yes 2 200 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Aunt s Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After thi funeral 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Residence 1 Jural 5 Pending death. Director: / investigation 1 ☐ Yes 2 ☐ No 2 Naccident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by illed in by 4 | Homicide To the Hospital 1 Setifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Prin Jimonson Mi 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of Marylar		rtificate of		-	Reg. No.	0.7	21055
H	Physici	an	1. Decedent's Name (First, Middle, Last Lingard Morri					2. Date of De Month	Day	Year	3. Time of Death
ì	/Medic		4a. Facility Name (If not institution, give		•	4b. City, Town, o	or Location of Death	JUN	4c. Count	2007 y of Death	5:37 FM
			Saint Joseph 5. Social Security Number 6. S			If Under 1 Year	Tows	O Ti 8. Date of Bir			imore
Ì	Funeral Director			M 2□F	77Yrs.	Months Days	Hours Min.	(Month, Da Aug. 2	y, _{Year)} 3 , 1929		lace (State or Foreign try) MD
	ryland how at		10a. State 10b. County		ty, Town or Lo	cation				1	0d. Inside City Limits
	he Ma 28a-f s otified	Director		ore a	arney	1407 71 0 1			40 000	148	1 ☐ Yes 2 No
	23a or 2 ust be n	ral Dir	10e. Street and Number 3033 East Ave.			10f. Zip Code 21234			10g. Citizen of USA		try?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IN "Item Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Ves 2 No Ai If Pes, Give Year or Dates: Force	r	Was Decedent of Information of Info	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - Americ ack, White, Mhite	etc.
ָה ה	n 72 h "natu	letec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind of E		•
7 7	d withingiene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	Brio	cklayer	u)		Consti	ructio	n
yland	uld be file Aental Hy, rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) John Sperl, Sr.				18. Mother's Name Florence	e (First, Middle, ce Harpl	Maiden Surna e	me)	
Mary	and 2 shore alth and N 27 Is mast rauma		19a. Informant's Name/Relationship (** Nancy Sperl- Sp	Type. Print) OUSE	19b. Mailir 303	ng Address (Street 33 East A	and Number or Rur Ve. Carne	ral Route Numbe Ey, MD 2	er, City or Town	, State, Zip	Code)
paltimore,	Pages 1 ament of He ant: If Item lury or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Inclinioval noni State The	ans Funea	sition (Name of matory or other pla cal Chapel	0/20	Date 2/2007	20c. Location Forest I	Hill, M	D
Dall	permit. Depart Import any Inj		21. Signature of Funeral Service Licen	see Landar	Pa	Name and Address Name and N	s funeral of 00 Harford 1	hapel & C Rd, Parkv	remation ille, MD	Servio 21234	es
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the deal one cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. METASTAT Due to (or as a conseq		IG CANCE	R			-	<u> </u>
	Examiner	-	Sequentially list conditions,	b. Due to (or as a conseq	unanco ofli						
./	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C C C C C C C C C C C C C C C C C C C	querice ory.						
00/00°	oe exec cian an ourial-tr	I Ex	resulting in death) Last	Due to (or as a conseq	juence of):				-		
000	rificate be executed g physician and as the burial-transit	edica		d				· · · · · · · · · · · · · · · · · · ·			
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn. 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	al death 3 □	Ectopic pregnanc Other (specify)	у			ate of delive onth	ry Day Year
colus, r	quires that in signed b	by	Part II. Other significant conditions of CHRONIC OBSTRUC	-	•	, ,	veп in Part I.				e cause of death?
ושבנו	The law re ate has bee page 2 sho	Completed	DIABETES MELLIT	US TYPE II				24a. Was autor perfo 1 Yes	an 24b. osy rmed? 2 X No	death?	psy findings available npletion of cause of
	siclan; certific rector,	Be	25. Was case referred to medical examiner?	Hospital: X		Oth	26. Place of Deat				
5	g Physter this neral di	n: To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	1 3 DOA	4 LI Nursing Ho	me 5 Residence 128d. Describe h		1-1	/)
200	tendin leath. tor: Af the fur	catio	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	M 1	Yes 2□No				
2	Ital or At rs after d ral Direc led in by	Certification:	4 Homicide determined	building, etc. (Specif				City or Tow	vn, State)		l Route Number,
	the Hosp in 24 hou the Fune pletely fil	Medical	one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death	occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)
	With Con	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date sign	A (D	
			30. Name and address of person who of	completed cause of death (Iten	n 23a) (Tvpe.	Print)	37254		2/2	100	<u>T</u>
	12+1		31. Date filed (Month, Day, Year)		, , , ,	,	, TOWSON	MARY	/LAND	21204	4
	Sta Registra		JUN 2 9 200	M Pagistrar's Signa	ature Kan	P. 9					

		State of Maryland / De	partment of Health and M		•	
		_ FOI	ertificate of Death	Reg.	- 7 1111 /	2/057
*		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physi /Me	ician dical	LILLIE MAY SMITH		June 27		8:00 p ^M
Exam	niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funera	al	FUTURE CARE - CHARLES VILLAGE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BALTIMORE y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A 9. Birthr	place (State or Foreign
Directo		219-22-1180 1□M 2 XX 78 Yrs.	Months Days Hours Min.	(Month, Day, Yea AUG 24 19		htry) H CAROLINA
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
Maryl -f sho	ţ	MARYLAND N/A BALT	IMORE			1 XYes 2 No
th the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
ath wi		4301 GLENARM AVENUE	21206		U.S.A.	
ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 □ Never Married 2 □ Married 1 □ Yes 2♥ ↑ ↑	 Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No- Rican, etc.)	Black, White,	
5-UU36 72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Ş.	3 TWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 2ON No <i>Specify:</i>		Specify: BLA	CK
72 hc	letec	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired)	ing 16b	. Kind of Business/In	dustry
within iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OUSEKEEPER		HOTEL	
Waryland Z IZ 12 should be filed withir h and Mental Hygiene. 7 Is marked other than traumatic event, the Ms	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Surname)	
yian ould be Mental arked o	2	DANIEL BERRY		LLE ROBERT		
Mar d 2 sh th and th and 7 Is m traum			alling Address (Street and Number or Run			,
ire, IMBITYIBING ZIZID-UU3D s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dis	301 Glenarm Ave., In position (Name of rematory or other place)		. Location - City or To	
altimor		NABurial 2 Cremation 3 Hemoval from State	RE NATIONAL 07-02	2-07 BA	LTIMORE,	MARYLAND
Dalltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other	ouce	21 Signature of Funeral Service Licensee	22. Name and Address of Facility WILLIAM C BROWN COM 1206 W NORTH AVENUE	MUNITY FU	NERAL HOM	E P.A.
		23a/Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)	lung Com	Clu		Onset and Death
/Medica Examine		Due to (or as a consequence of):	(
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying. Due to (or as a consequence of):		n		
executed n and ial-transit	Examiner	trat finaled events	ula accid	lent		
pricia be	亞	Due to (or as a consequence of):				
oo/ ifficate g phys as the		d				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)		23d. Date of deliv Month	ery Day Year
law requires that as been signed be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	he cause of death?
aw rec	Completed			24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
The cate has page	Som			performed 1 Yes 2 ☐	? / death?	2 □ No
VILAI IN sician: The certificate h rector, page	Be	25. Was case referred to medical examiner? Hospital: Other:	n (Check only one)			
Physer this eral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Residence 28d. Describe how in	e 6 □Other (Special	(5)
arth. or: Afte	ation	1 ☑-Matural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No			
UNISION OF all or Attending Phy s after death. IN Director: After this ed in by the funeral of	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
ne Hospii n 24 hour ne Funer bietely filli	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
To the company of the	Ž	29b. Signature and title of certifier m)	29c. License number D 3 4 6 4	29d.	Date signed (Month,	
		30. Name and address of person who completed cause of death (Item 23a) (Typ. 2H0A113 A. H3 H3N1; \$2(N) E	e, Print) (TAW St Shilt	304, BA	LTIMOKO	= MD 2/20
	State	31. Date filed (Month, Day, Year) JUN 2 9 2007 32. Registrar's Signature	parti			
Regis		July o con la serie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Betty Jean Skwarek 26, 2237 June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Med. Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 60 213-52-5628 **Director** May27,1947 Md. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Fallston Md. Harford 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21047 1322 Terry Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Billing Hospital 12 yrs. Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should bet Department of Health and Mental - Important: If item 27 is marked oil any Injury or other treasment. Theresa Papalia Vernon Poling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Terry Way Fallston Md. 21047 19a. Informant's Name/Relationship (Type. Print) 1322 Terry Way Fallston Md. Barbara Lucich sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 29 Bayview Crematory Baltimore 2007 21. Signature of Formal Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bone 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3∐ DOA 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one)

within 24 hours a To the Funeral D

State

5

29c. License number

milleri M.O. 5 Midcrest Gt. Baltimore, MO 21286

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vella

31. Date filed (Month, Day, Year)
JUN 2 9 2007

ATTENDING PHYSICIAN

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** Shirley Vivian Shouman 2:15 A M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Healthcare Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 23, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 M 2 X F 219 12 8855 84 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits if item 27 le marked other then "naturel", or iteme 23a or 28a-f ehow or other traumatic event, the Modical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1050 Middlesex Rd. 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ould be filed within 72 hours after Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked eny injury or other traumatic events. George Kromm Helen Flowers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Gralia (Daughter) 7953 Wheatridge Ct. Indianapolis, Indiana 46268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bayview Crematory 7/2/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility} Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature/of Funeral Service Licensee onn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical HEART FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed physicien and Physician/Medical es the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 Yes 2 To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 1 Tyes 201 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner et Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Matural 5 Pending 1 ☐ Yes 2 ☐ No death Accident completely filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Markel-

3

State Registrar

9

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For State	State of Maryland	•	irtment of F tificate of I			JIENE leg. No.	1	01000
			Registrar 1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		3	3. Time of Death
П	Physicia	an	•					Month	The state of	Year	8 1 M
1	/Medic		4a. Facility Name (If not institution, give	IREET		4h City Town o	r Location of Death	JUNE .	4c. Cou	nty of Death	1.00
1	Examin	er				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				_	
		344	Northwest Hosp 5. Social Security Number 6. Se		ast birthday)	Ran If Under 1 Year	dallsto If Under 24 Hrs.	 8. Date of Birth 	1	Balti 9. Birth	place (State or Foreign
	Funeral Director		1	□м % □ F	Yrs.	Months Days	Hours Min.	(Month, Day		Cou	intry) SC
	ri pandich		220-14-1914 Usual Residence of Decedent	86				04 02	2 21		
	/land ow		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Man Fr sh	ţo	MD NA		Balt	imore					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Cîtizen	of What Cou	intry?
	3a o	묘	2121 Windsor Ga	rden Lane la	13D	2	1207		TT	S.A.	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14.	Race - Ameri Black, White	can Indian,
က	after or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give	1	Tes, specify Cubi	Specify:	io i licari, etc.)		.,	
ĕ	ral", c	b	3 X Widowed 4 ☐ Divorced	Year or Dates:		□ 165 2□ Λ 10	эреспу.		Spe	ecify: B	lack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occup kind of work done	during most of wor	rking [16b. Kind o	f Business/li	ndustry
2	thin se.	혈	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d) -				
2	ed wi	S	12th grade	na	Fa	ctory W		(F) 1 14:14			old Co.
pu	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sur	name)	
<u>yla</u>	Men Men arke	은	Harley Stewart				Gussie				
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	g Address (Street	and Number or Ru	ural Route Numbe	er, City or To	wn, State, Z	ip Code)
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.		Lillie Ervin-Co				Ave, Ba		bM_ve	212	
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		lace of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Locati	on - City or T	own, State
Ĕ	Pag nent ant: I		4 Donation 5 ☐ Other (Specify		ng Mei	norial	Park 6/	30/07	Rand	allst	won, Md
att	porti porti y Inj		21 Signature of Funeral Service Licen	* 1/		Name and Address R/					
<u> </u>	89 5 8 5		Sante	Ves Hano	11 4	300 Wab	ash Ave	. Balti	more	, Md	21215
		-	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	5 - 2W000	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	MASSIVE	Kin	NONA	RY FI	MROL	SIVI		Onset and Death
1	/Medical		resulting in death)	a. Due to (or as a consequ		112111					
8	Examiner		Sequentially list conditions,	ADENCEA	REIN	AMOL	90	LITER	US .		
-		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ			b				
1	nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· CHRONIC	0125	TRUCTI	VE YUL	MONY	try	DISI	arse '
Ö,	icate be executed physician and s the burial-transit	E	resulting in death) cast	Due to (or as a consequ	ience of):				1		
8760,	ate b hysic he bi	dical		d				<u> </u>			
U	ng pl		IF FEMALE:								
Вох	death certifi e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna	Ideath 3□	Ectopic pregnanc	у		23d	Date of deli Month	very Day Year
	e des he at ed fo	sici	1 ☐ Yes 2 No	4□Pregnant at time of d 9□Unknown	eath 5	Other (specify) _					
P.0	at the I by the	h Y	9 Unknowń				una in Dant I	220 Did to	obacco use	nontributo to	the cause of death?
	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to death but not rest	liting in the u	ndenying cause gr	ven in Part I.				
ğ	w require been si should b	pe						1 🗆 '	Yes 2 1	10 3∐ FI	obably 4 ∐Unknown
SC	e law r has be ie 2 sh	Completed						24a. Was autor		4b. Were au	topsy findings available completion of cause of
Ě	The sate has page	E O						perfo 1∐ Yes	rmed? 2 X No	death? 1 ∐Yes	2 ™ No
or Vital Records,	ı lcian: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o	ne)		
Z >	Physician: r this certific ral director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Otl	ner: 4 Nursing I	Home 5□Resid	dence 6	Other (Spec	cify)
0	ding Pho	ü	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo	ry at rk?	28d. Describe I	how injury o	ccurred	
Division	Attending r death. ector: After by the fune	atio	Natural 5 Pending investigation]Yes 2□No	-			
Vis	or Attendatter death	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (3 City or Tox		umber or Ru	ral Route Number,
Ö	s afte safte	Certification:									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			nysician: To the best of my kno miner: On the basis of examina							
	he H n 24 he Fi plete	Medical	one)	and manner stated.					Jano and ph		
	To t To t	Σ	29b. Signature and title of certifier	P mahl	m.	29c. Licen			29d. Date s	igned (Monti	h, Day, Year)
	/		- Luching	1 11 CAL	7 111.	OB	41410	·	JUNE	32.	, APU (
	h		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print) The	INCER	PIME	ATH		
	.,		MORTHWEST	HOSPITAL	CEN	ITER	RANG	ALLST		m	031133.
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	0					
	Regist										

Physicia /Medic Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at anone. $(\rho/2,3/07)/8/6\rho$ Baltimore, Maryland 21215-0036 Physician /Medical Saw Vers Dulse M800475878 Division or Vital Records, P.O. Box 68760, Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	State of Maryland / Department of Health and M		_	C .								
٠	1 - For State Registrar Certificate of Death	Reg.	0 : 3	7 210	51							
÷	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Y	3. Time of D								
n il -		June 23,	2007	18:16	М							
r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Harfor									
	Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9	. Birthplace (State or	Foreign							
	. Months Days Hours Min.	(Month, Day, Ye Mar. 19,		Vest Virgi	nia							
	Usual Residence of Decedent			10d. Inside City	/ Limits							
ŏ	Total data			1 □Yes								
rect	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code	10g.	Citizen of Wha	at Country?								
בו ה	1611 Dogwood Lane, Bel Air, Maryland 21014	τ	ISA									
ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)		American Indian, White, etc.								
y Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: 3 □ Wildowed 4 □ Divorced Year or Dates:		Specify:	White								
g pa	15 Decedent's Education 16a. Decedent's Usual Occupation		b. Kind of Busir	ness/Industry								
plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ding										
Completed by Funeral Director	12 Homemaker		Own Hor									
To Be (The fall of statute (1 no.) mission, easy	e (First, Middle, Ma	iden Surname)									
2	Goolge (Intel) Distinct	Lla Hash	ity or Town St	tate Zin Code)								
				ity or Town, State								
	1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Darlington Cemetery 6-29-	-07 Da	rlingto	on, Maryla	ınd							
	21. Signature Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho	me, P.A.		*								
	1317 Cokesbury Roa	ad, Abingo		ryland 210								
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	ι,	Interval Betwood	veen							
	Immediate Cause (Final disease or condition resulting in death) a Septic Shock											
	Due to (or as a consequence of):	241	/ C l									
er	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying b. Due to (or as a consequence of):											
Examiner	Cause (Disease or injury that initiated events c.											
	resulting in death) Last Due to (or as a consequence of):											
dical	d											
Completed by Physician/Medic	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date	of delivery								
iciar	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Mont	h Day	/ear							
hys	9 Unknown											
bλ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba		oute to the cause of d B ☐ Probably 4 🖼								
ted	Coronary artery disease											
mple	Diabete mellitis	24a. Was an autopsy	ed? pr	ere autopsy findings for to completion of c eath?	ause of							
ō	25. Was case referred to medical 26. Place of Dea	1 Yes 2 ath (Check only one)	□No 1[☐Yes 2☐No								
o Be	examiner? Other:	lome 5 Residen	ce 6 □Othei	r (Specify)								
n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Vorkatural 5 Pending (Month, Day Year) 28b. Time of 1 Nork?	28d. Describe how	injury occurre	d								
atio	2 Accident investigation M 1 Yes 2 No	200 1		r or Rural Route Nun	abor							
ijij	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	State)	i oi nuiai noule ivuii	iber,							
20	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the car	use(s) and man	nner as stated.								
Medical Certification: To	((Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, da	te and place, a	nd due to the cause(s)							
Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed	(Month, Day, Year)								
	Itel Casain Klaral 063420	٦	une, 2	15, 200								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	av. n.	Dal.	13, 2007 AGMO	אומוכ							
te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zubair Khara, M.D. 500 Usper Chesase 31. Date filed (Month, Day, Year) JUN 2 9 2007	ned	- De la	Dying	רוטוא							
ie ar	JUN 2 9 2007 Alexan 18 April											
_					_							

Sta Registi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^D2y007 **Physician** June 26, 9:45 A M ELIZABETH R. SICILIANO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔼 F Feb. 13, 1921 New York 157-03-2293 Director 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 1 XYes 2 No Directo Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or dical Examiner must be USA 21014 144 Hickory Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify: ≥ 3√ Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth (nmn) Madden Thomas (nmn) Ryan Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 717 Roland Ave., Bel Air, Maryland 21014 Eugene Siciliano / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Catherine's Cem. 6-29-07 Wall, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Buckley Funeral Home 509 Second Ave., Asbury Park, New Jersey 21. Signature of Funeral Service Ligensee 07712 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumothorax **Physician** disease or condition resulting in death) /Medical pulmonary Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent prognant in the past 12 yonths?
1 ☐ Yes 2 ☑ No 3 □Ectopic pregnancy Month Year 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vonknown Completed . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ၉ 1 Tyes 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) (00, mD

Registrar DHMH 17 Rev 1/2001

U

32 gegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAO

Ringlin Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $\overset{\text{Day}}{2007}$ Physician Mildred M. Swank June 24, 9:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F May 214-18-5790 87 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11225 Waycross Way 20895 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: White 1 ☐ Yes 2 No þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl E. Plitt Marie Nies 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trauonce. Karen Rogers/Daughter 6004 Queenston Street, Springfield, VA 22152 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State June Date 9 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 Donation 5 Dother (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service License M01346 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1ETASTATA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, tue to for es a consequence off Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Dav 5 Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes ŻX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perfor To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 phpatient examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day 1 Yes 2 No 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

The law requires that the death certificate be executed Box 68760 9:15 am JUNE 24, Ö been signed by should be detact Δ, Division or Vital Records, SWANK, MILDINGO cate has page 2 s certificate Hospital or Attending Physician: After within 24 hours after deau...

To the Funeral Director: Af

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

marked other

h and Mental F

traumatic event, the Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Medical 2

29a. Certifier

(Check only one)

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

023308

29d. Date signed (Month, Day, Year) JUNE 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NCION M. DNIEGO, MO 6420 RNCKI FOR

6420 ROCKLEPGE DR. #4100 BETHESDA, MD 20817

31. Date filed (Month, Day, Year)
JUN 2 9 2007

			For State Registrar	State of Ma	aryland / [rtment of He		Mental Hy	giene	7 21064
			Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath	3. Time of Death
	Physicia		JOAN B.S	TULTZ	-				JUNE	27. 200	7 2:33 P ^M
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Dea		4c. County of	
	Exami	Ť	CARROLL HOSPIT	AL CENTER	?		WEST	MINSTE	R	CARI	ROLL
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	av. Year)	. Birthplace (State or Foreign Country)
	Director		220-42-7188	1□M 32F	61	Yrs.	Monaio Buyo		11/13	/1945 1	MARYLAND
	g ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Loc	ration				10d. Inside City Limits
	shor	Ä		.T.T	WEST						Y Yes 2 □ No
	28a-f	ecto	MD CARRO	, L	WEST	IAT T IA	10f. Zip Code			10g. Citizen of Wha	at Country?
	a or	급	24 WEBSTER ST	1			2115	:7		USA	1
	eath	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cubar		Specify Yes or No		American Indian,
	fter d	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅					rto Rican, etc.)		White, etc.
8	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify:		Specify:	WHITE
21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-f show the Medical Evanither mult be rolllind at	Completed	15. Decedent's I (Specify only highest g		16a	. Deced	ent's Usual Occupa	ition Juring most of we	orking	16b. Kind of Busin	ness/Industry
21	within 7 ene. than "t	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	OO NOT use retired,)		auth au	
21	a filed will Hygien other th	Co	12				CLEAN		ana (Cina & Adiodollo	CHURCH	
<u>n</u>	0 0 0	Be	17. Father's Name (First, Middle, Las	ULLIAM YII	NGT.TNG					, <i>Maiden Sum</i> am <i>e)</i> COBER TS O	
3	should ind Men ind marke umatic	မ				Mailin	a Address (Street a				ate, Zip Code 21157
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship							, WESTM	
	thealt Healt Item 2 other		ROY E. STULTZ,	III -S	20b. Place o	f Dispos	sition (Name of		Date	20c. Location - Ci	
10			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				natory`or other place Y CREMA'		/1/07	SYKESVI	LLE. MD
Baltimore,	그 문문을		21. Signature of Funeral Service Lie		7				-		L HOME, P.A.
Ba	Depar Impo any it		PRY M	11.15							, MD 21157
			23a. Part 1. Enter the disease, or coshock, or heart failure. List on	inplications that caused	the death. Do	not ente	er the mode of dying	g, such as cardi	ac or respiratory	arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final	y one cause on lach in	DIAC	1	PRRES!	7			Onset and Death
	/Medical		disease or condition resulting in death)	Due to for as	2 2002200110020	of).					-
	Examiner			VE	NTRIC	UC	AR FI	BRILL	ATTO	\checkmark	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a cursoquarico	JIJ.					
3	cuted nd ransi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C.			NSION				
,092	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence	of):					
876	<u> </u>	llcal		d							
x 68	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physiclan/Med	IF FEMALE:	22a If was auteome	of prognancy				***	and Date	of dollarons
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date Month	
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	time or death	3	Ottier (specify)				
Д	that the the the the the the the the the th		Part II. Other significant conditions	contributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
ds	uires sign ld be	d by	DY	SLIPII	EM/	1			1 🗆	Yes 2 No 3	☐ Probably 4 ☐Unknown
Records,	w requir been si should	Completed	DI	ARETI	EQ 1	ME	LLITE	25	24a. Wa	s an 24b. We	ere autopsy findings available
Re	The lav	mc		110.27		- 112			per	ormed? de	or to completion of cause of ath? Yes 2 No
Vital	iclan: Th certificate rector, pag	C	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only		7103 20110
5	ysiclan: is certific director,	0 B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ERVO	utpatien	t 3 DOA Othe	ar		sidence 6 Other	(Specify)
10	ding Phy h. After thi funeral	n:	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Injun Worl	at k?	28d. Describe	how injury occurred	d
0	ath. rr: Aft	atlo	1 Natural 5 Pending 2 Accident investigat	on	,	,,		Yes 2 □ No			
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a 286. Place of in	ury - At home, f c. (Specify)	arm, str	eet, factory, office			(Street and Number own, State)	or Rural Route Number,
ā	tafol rs aft al Di	Cer		il.					1		
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis o	f examination a	ge, death nd/or inv	occurred at the time vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) and mani , date and place, an	ner as stated. Id due to the cause(s)
	the hin 2, the from the from the from mplet	Jed	one) 29b. Signature and little of certifier	and manner st	ated.		29c. Licens	e number		29d. Date signe	(Month, av. Year)
	T will	-	296. Signature indune in certifier	nalla					46	11.7	All the second
,			Pageo			CT	Deien	007	ر د سامهال	IP TON	D
	3		30. Name and address of person wh	O completed cause of c	eath (Item 23a)	(Type,	M.D.	712	DAINE T	VETON TER M	ID 21157
		ate	31. Date filed (Month Pay, Cont)	0007 34 mistr	or Sinfaure	100	de	VE51	MINOS	THE I	
de	St. Regist		JUNZ 9 2	001		1					

Francis Milton	Scot	tt, Jr. State of Maryland / Department of Health and 1- For State Certificate of Death Registrar	d Mental Hygiene	1 2 105
Physic Medical Exar		1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Month Day Year	Time of Death 0923 hrs
3 **		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or	Location of Death 4c. County of Death	
Funera		200 East Elger Street Union Bridg 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea		ace (State or
Directo		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day:	Foreign	y) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10	d. Inside City Limits
and [] show s	<u>ة</u>	MD Carroll Union Bria	190	Yes 2 No
212;5-0036 Mental Hygiene Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f show marked there than "natural", or items 23a or 28a-f show marked there than "natural", or items 23a or 28a-f show marked than "natural", or it	Director		10g. Citizen of What Country? USA	?
ath with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His 1 Never Married 2 Married Armed Forces? 11. Marital Status 12. Was Decedent of His	spanic Origin? (Specifý Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	Indian, Black,
after de	by Fu		specify: Specify: Bla	:CK
2 hours	ted t		. DO NOT use retired)	
0036 within 72 hours after siene free than "natural", o	Completed	12+h grade N/A Chef 17. Father's Name (First, Middle, Last)		
ID 21215-0036 Should be filed within 7 and Mental Hygiene 77 is marked other than	BeC	Francis Scott, Sr.	18.Mother's Name (First, Middle, Maiden Surname) Helen Taylor	
AD 2 shc 27 is	To	19a. Informant's Name/Relationship (Type, Print) Helen Scott/MDther 1537 Shel	et and Number or Rural Route Number, City or Town, State, Zir Field Road Balto Mb :	21218
more, M Pages I and 2 ient of Health		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cerematory or other place)		
altin mit. P spartme	5	4 Donation 5 Other Specify: St. Stanislans 21-Signature of Funeral Service Licensee 22. Name and Address	of Facility Voughn C. Steene Fu	
on ឱ្យ គឺ: Physicia		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying,	such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medica		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
		Seguentially list conditions, b		
	Examiner	if any, leading to immediate Oue to (or as a consequence of): Clisease or injury that initiated C		
outed and	Exa	events resulting in death) Last Due to (or as a consequence of): d.		
50, te be executed tysician and	edical	X MENDED X #Za,PII,27,perME,g870, 8/9/07 TT	// #5, perFH	
Box 6876(the death certificate the attending physical for the attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy 23d. Date of delivery Month Day	Year
Box (death or death or he attend	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		
that the d	by Pt	,	given in Part I. 23e. Did tobacco use contribute to the	
ords, P.O. w requires that the is been signed by	eted		24a. Was an 24b. Were autops	sy findings available
tal Records cian: The law requi	ompleted		autopsy prior to comperformed? death? 1 ✓ Yes 2 No 1 ✓ Yes	pletion of cause of
Vital Recc ysician: The lav his certificate ha	Be C	examiner?	of Death (Check only one) Other: Some 5 Residence 6 Other: Some 5	
ing Physi After this	H-	1 Ves 2 No Impatient 2 Erootipatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other: Sorry at Work? 28d. Describe how injury occurred	cene
ion (trending leath. tor: Af	ation	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	Yes 2 No	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. The law peer her peer the serial property of an Director. After this certificate has been signed by the human director mass? A health the death.	Certification:	3 Suicide 6 Could not be determined (Specify)	ouilding, etc. 28f. Location (Street and Number or Rural or Town, State)	Route Number, City
Division of Vital Records, P.O. I To the Hospital of Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the Companient William has the financial director mose, 2 should be deached.	Medical C			
T. Wilson	Μe	and manner stated. 29 Signature and title of certifier 29c. Licens	e number 29d. Date signed (Month,	, Day, Year)
		tatrici bronica - Pollohous O.C.	M.E. June 26, 2007	
X			reet, Baltimore, MD 21201	
Regi	State			
		JUN 6 3 LYVI		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 21 per SA, g868, 06/29/07 the Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Jay C. Torres June 16, 2007 1:37 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Linder 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours Days Min. Months 1 M 2 ☐ F 37 Director 147-60-9699 Jan. 11,1970 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show must be notified at MD 1 ☐ Yes 2 No Montgomery Director Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 17911 20877 Cotton Wood Terrace items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Yes 2□ No Specify: mexican à Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Unk 16b. Kind of Business/Industry Unk than Elementary/Secondary (0-12) 12 College (1-4or 5+) the permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienre Important: If item 27 is marked other ths any linuy or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesus Torres Barbara Ghee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Torres/mother 17911 Cotton Wood Terrace, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ★Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility per DVR State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Ronald S. Wade, Director 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -ntercrania /Medical Due to (or as a consequence of) Examiner per S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death I□Yes 2□No signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2. No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 110 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannes of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:.

completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd

Bethesda mn 20814

State Registrar MD

D0060117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Edith Virginia Thompson 3. Time of Death 11:50 A 2. Date of Death June 24,2007 Year 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lutherville Genesis Brightwood Center 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Octoor 2 y 1 Year 3 6. Sex 9. Birthplace (State or Foreign New Interpretation 5. Social Security Number 1 □ M 2 F 212-28-3319 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville MD 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2413 Ellis Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 🍒 ☐ No Specify Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Sterling Florence Seaman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2411 Ellis Road-Parkville, Maryland 21234 June Flynn-daughter 20b. Place of Disposition (Name of cametery, crematory or other place) Carcins of Faith Cametery 20a. Method of Disposition 20c. Location - City or Town, State Rosedale, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,MD 21234 EVANS TÜNERAL CHAPEL AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SLESSLUVA SILLAM DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHO LANGIO CARCINOMA 24 No 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? 26. Place o Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed physician and s the burial-trans Box 68760. attending p Division or Vital Records, P.O. page 2 s Hospital or Attending Physician: funeral director. this af er death. the

Examine

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2.
Department of Health an.
Important: If Item 27 is many Injury or other

Physician

/Medical

Examiner

death with the Maryland

homoson, Solita

Baltimore, Maryland 21215-0036

Physician/Medical Be Certification: To

ģ Completed

within 24 hours after dea To the Funeral Directo completely filled in by th

Medical

4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3 ☐ Suicide

6 □ Could not be

and manner stated.

Registrar's Signature

RUAN SO

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

TOWSON MA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JUNE 25

29b. Signature and title of certifier

D47945

29d. Date signed (Month, Day, Year)

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CINA, Au un 7565 OSLON - DAINE

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend state of Maryland / Department of Health and Mental Hygiene

							Cer	tificate of	Death		Reg. No.		
			1. Decedent's Name (First, Middle, Lest)					2. Date of Month			of Deeth 3. Time of Death		
	ysician		Rose Carreiro Vieira						06		007	5:00 pm	
	Medical kaminer	4			street end number)				4b. City, Town, o	or Location of Deet	h 4c. County	of Death	•
EX	Territine.		ov Chasa	Nurcina	& Rehab C	onter			ilver s	nring	Montg	omer	V
, F.	ooral		. Social Security N	umber 6. Se	ex 7. Ag	e (In yrs. lest b	birthday)		ilver S If Under 24 H Hours M	rs. 8. Date of Bir in. (Month, Da	th H	9. Birthi	blace (State or Foreign
∘ Fun Dire			16-16-69	1	□M 2 X F	86	Yrs.	Months Days	TIOUIS M	4-29-19			achusetts
	4		Jsual Residence of										and traids Office Limite
yland	=	1	0a. State	10b. County		10c. City, To	wn or Loc	ation				1	10d. Inside City Limits 1 Yes 2 □ No
Mar.	pe to		MD Montgomery Silver Spring										
within 72 hours after death with the Maryland ene. Taturel, or items 23e or 28e-f show	unt be notified at	1	10e. Street end Number 10f. Zip Code							10g. Citizen of \	What Cou	ntry?	
WIE 38 0	1 C		2015 East West Highway					20910			USA		
ter deat		1	1. Marital Status	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Decedent Ever in U,S.			Vas Decedent of I	lispanic Origin?	(Specify Yes or No		14. Race - American Indian, Black, White, etc.	
after or ite	\$ B		1 Never Marri	ied 2 Married	Armed Forces?	No				,			
urs s	مَ ا	2	3 Widowed	4 Divorced	tf Yes, Give Year or Dates:		ILI Yes		s 2 No Specify:			Specify: white	
72 hours	rt, the Medical Ever Completed by	1	/0	15. Decedent's Ed	lucation			e. Decedent's Usual Occupation (Give kind of work done during most of work		working	16b. Kind of B	Kind of Business/Industry	
hin 7	event, the Medical Be Completed		Elementery/Seco		College (1-4or	5+)	life. L	life. DO NOT use retired)			T3 . 1	0 -	
filed within Hygiene.	# 0	5			1		Jocum	ent Anal			Federal		ernment
	a		17. Father's Neme	(First, Middle, Last)					18. Mother's N	Name (First, Middle	e, Maiden Surnar	ne)	
lenta Ked	To B		Manuel S	oars Carr	eiro					Rosa Cab			
12 should be n and Mental	other treumetic	100		ame/Relationship (1	9b. Mailin	g Address (Stree	t and Number or	Rurel Route Numi	ber, City or Town	Stete, Zi	p Code)
4 th	. —		Edward Ca	arreiro/b	rother					x 1081 Tr	ruro, MA	0266	56
Health	te	2	20a. Method of Dis			20b, Place	of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location	-	
age: ant of	7 9			☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	Pine	Grov	- Cemete	ry	7/2/2001	New Be	dfor	d, MA
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or any Initro contact returnation want.		1		neral Service Licer			22	. Name and Addr	ess of Facility	1	Ç;1	ver '	Spring
Dep	o o			0	and me	01358	Ra	nn Funer	al & Cr	em. Svc			MD 20910
		4	000 0 11 5	the disease as as	plications that cause								Approximate
			shock, or hea	art failure. List only	one cause on each I	ine.	3 0110		J				Interval Between Onset and Death
Physi /Mor	ician dical		Immediate Cause	(Final	T.							İ	
Exam		Immediate Cause (Final disease or condition resulting in death)											
			,			Due to (or as	a conseq	uence of):				1	
p p	or the bunal-transit				b								
raquiras that the death certificate ba executed seen signed by the attending physician and hourshood for use as the knindstransit	al-tra	Yal	Sequentially list conditions, if eny, leading to immediate									ļ	
ba e	buri.		if eny, leading to immediate cause. Enter Underlying Cause, (Disease or injury c										
icate	s the	į	d									\$ \$	
certif	Sa as	Ē									- 1		
eath (igned by the attend be datached for us: by Physiclan/	<u> </u>								d tobacco use co	ontribute	to the cause of death	
ha de	ched ched	2	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Cerebral Infarctions							Yes 2□ No		obably 4 Unknow	
thatt	data data								_ ''	_ 100 - EL 140	2011	. ~	
iras t	ed b	2									Z-a. Tres all autopsy		Were autopsy findings
radu	should I		Diabetes	Mellitus	Type 2					per	formed?		vailable prior to completion of cause of death?
	paga 2 should	2									J.		
eff de	pag	5	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No									TLI Yes 2LIN0	
clan:	Sector.	מ	25. Was case refe examiner?	rred to medical	Hacaital					Deeth (Check only			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this cartificate has b completely filled in by the funeral director, paga 2 s	al direct	0	1 ☐ Yes 2	No		ient 2□ER		nt 3LI DOA		ng Home 5 □ Re			cify)
	unera		 Menner of Dee Matural 	eeth 5 🗆 Pending	28a. Date of Inj (Month, D	ay Year) 28	28b. Time of Injury at Work?		ZOU. Describ	28d. Describe how injury occurred			
ath.	or: A thattu		2 ☐ Accident investigation M 1 ☐ Yes]Yes 2□No	204 1	(Street and Non	her or Di	ıral Route Number
r Att	rect by d	Cermication:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)				City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
rs aff		2								1			hateta
noq 1	ely fill	edical	29a. Certifier (Check only	Certifying Pl	nysician: To the besi	of examination	dge, deat and/or in	h occurred at the vestigation, in my	time, date end p opinion, death o	lace, and due to the concourred at the time	e cause(s) and n e, date and place	, and due	to the cause(s)
he H in 24	plete		one) end manner stated.								29d. Date signed (Month, Day, Year) June 28, 2007		
To t	100 E	Σ	29b. Signeture end title of certifier 29c. License number										
			1	Van 9	e le	gal	1	D5226	1		June 2	8, 2	UU /
	n		30. Name end add	iress of person who	completed cause of	death (Item 23	3e) (Type	Print)					
	3		Alan R.	Segal, M.	D.1517 Hu	gd Cir.	Sil	ver Spri	ng, MD	20906			
	State	e	31. Date filed (Mo		117 32 Regis	trars Signatur	θ	ale					
B	Registra			THINGS	100	Car of a	17						

DHMH 16 Rev 6/95

Registrar

Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 Thelma V. Winstead 2.6 June 3:56A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 103 Lee Lawrence Ct. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Apr 28 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 7 F 219-54-3961 57 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Marvland Baltimore Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 103 Lee Lawrence Ct. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th O <u> Assembly Line Worker</u> <u>General Motors</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Wesley Conway Mary Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, 1, 2, 2, 2 Department of Health Important: If Item 27 any injury or other tr James E. Winstead Sr. (Husband) 103 Lee Lawrence Ct. Baltimore, Md. 20a. Method of Disposition 20b. Plane of Disposition (Name of cemetary, crematory prother place) 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6-29-07 Memorial Gardens Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Winname Reverse of SaciliSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Lan eese 100883 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** se conds /Medical Due to (or as a consequence of) Arter Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an page 2 s autopsy this certificate 1 Yes 2 No or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only gne) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural within 24 hours after com...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Feeser 2112 Dundal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				1 - State of Maryland / Department of Health and No. Certificate of Death		giene Reg. No. 0 0 7	21071					
		9	4	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death					
		Physicia /Medic		Ella Evelyn Wickman	June	24 2007	905 PM					
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death						
		Funeral	,	Bel Air Health a Rehabilitation Center Bel Air 5. Social Socurity Number 6. Sox 7. Ago (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir		place (State or Foreign intry)					
	Way 1	Director		213-01-0393 1 M 2 F 91 Yrs. Months Days Hours Min.	July 2		ryland					
	700	D *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	2	•	10d. Inside City Limits					
	Many	-f sho	tor	Maryland Harford Abingdon			1√ Yes 2 No					
	4	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any highly or other traumatic event, it a Mudical Exerts are tunk for conflict at 2008.	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	intry?					
	4	238 (1811)	raiD	20 Box Hill South Parkway Apt. 407 21009		USA						
	ė de	ltems	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Marned 1 □ Yes 2 ☒ No	ecify Yes or No Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.					
	036	. O		If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: Wh	ite					
	5-0	natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ang	16b. Kind of Business/li	ndustry					
	121	than.	mpi	Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse		Health Ca	re					
	d 2	Hygie other	ပို	<u> </u>	e (First, Middle	, Maiden Sumame)						
	rlan	Aental Aental rked tic ev	To Be	Leo James McLhinney Albina (U	Ink) Duc	lek						
	Baltimore, Maryland 21215-0036	and he ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		ber, City or Town, State, Zip Code)						
	e, 7	Health Health Sm 27 ther tr		Donald McLhinney/Nephew 1511 Southview Road, E	Bel Air, Date	Maryland 20c. Location - City or T	21015					
	nor	nt of h		1X Burial 2 Cremetion 3 Removal from State								
	altin	ortan ortan Injury		4 Dohation 5 Other (Specify) Oak Lawn Cemetery 6-30 21. Signature of Funer of Sensit of Lourise 22. Name and Address of Facility McC		Baltimore,						
	ä	Den Imp	4	1317 Cokesbury Road								
		a		23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between					
		hysician		Immediate Cause (Final disease or condition a. Alzhilmir's Dimintin			Offset and Death					
		/Medical xaminer		Due to (or as a consequence of):								
		ate be executed hysicien and the burial-transit	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	pation		Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events c.								
	50,	cien a	EX	resulting in death) Last Due to (or as a consequence of):								
	38760,	the th	hysician/Medicai	d								
	Box 6	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	verv					
	B.	e death the atte hed for	sicia	In the past 12 months? 1 Yes 2 DNo 1 Letopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Month	Day Year					
	P.O	ed by the detached	Phys	3 Unknown								
	ds,	w requires been sign should be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	239. Dia t	obacco use contribute to Yes 2 No 3 Pro	the cause of death?					
Y.	Vital Records,		Completed		24a. Was		opsy findings available					
- W	Re	page 2	ошо		auto	prior to correctly death?	ompletion of cause of					
5			BeC	25. Was case reterred to medical examiner? 26. Place of Deat	↑ T☐ Yes	- Y	2 No					
-	of V	sidi.	7	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Warsing Ho		dence 6 Other (Spec	ify)					
Vickman,	onc	Attending Physician: r death. sctor: After this certific by the funeral director,	tlon;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (28b. Time of Injury (28b. Time of Injury) 2 Accident investigation M 1 Yes 2 No	28d. Describe	how injury occurred						
Ę	Division	after death Director: / in by the f	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		Street and Number or Rui	ral Route Number,					
3	Div	5 # 5 E	Certification;	4 Homicide building, etc. (Specify) City or Town, State)								
3	Div	within 24 hours after or the Fundrell Direct completely filled in by	edical	29a. Certifier (Check only Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)					
		0 0 0	O	one) and manner stated.								
	- £	a if in the	Me	29b. Signature and titte of certifier 29c. License number		29d. Date signed (Month)	. Day. Year)					
	T di of	Toth	Me		1							
	7	To the comp	Me	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	A -							
	5	within comp	W	D34652	Mary	June 25 June 21						

Amend #1 per MD g896 10/1/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per ME G882 8/26/08 TT
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Fred D. Whiting, Jr. 2 Date of Death Month **Physician** Fred B. Whiting, Jr. 3:24 AM 3007 20 JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BARTIMORE SAMARITAN HOSPITAL GOOD If Under 1 Year If Under 24 Hrs. Date of Birth Month Day Year Oct 7, 1958 Birthplace (State or Foreign
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X**□M 2□F 215-70-4990 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location X 1 □ Yes 2 □ No **Baltimore** Maryland N/A Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 21217 1332 North Woodyear Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry John Hopkins Hospital Elementary/Secondary (0-12) College (1-4or 5+) Engineer 12 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any light you other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha E. Whiting Fred D. Whiting Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1332 North Woodyear Street Baltimore, Maryland 21217 JoAnn Whiting Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State Lansdowne, Maryland 06/28/07 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Vicense 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 th. o not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the dise se, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEP SIS CENTRA YON APPROVED BY Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown KID HEY DISBASE 24b. Were autopsy findings available prior to completion of cause of death? LIVER 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 2 ER/Outpatienf 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury af Work? 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title office tifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2007

in than "natural", or items 23a or 28a-f show the Middeal Exemples to put by notified at

or other traumatic event,

Physician

/Medical

Examiner

attending physicien and for use as the burial-transit

certificate has

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics

as the

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Fred Whiting

Baltimore, Maryland 21215-0036

HOSP17AL

ATTONDITY PHYSICIA

32. Registrar's Signature

SAMARIZAN

30. Name and address of beach who completed cause of death (Item 23a) (Type, Print) MAW N = 00, MD

20063339

BARTIMORA

JUNG

2007

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b c per ffb 8869 7-11-07 vt

amend Item 23a per dr., g868, 06/29/01b

Reg. No. 2 0 0 7 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** A M WALKER LUCIN DA Tuns /Medical 2007 1115 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL If Under 1 Year | If Under 24 Hrs. BALTIMORE NURTH WEST 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 220-21-6171 Yrs MARYLAND 30,1930 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show the notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4914 "natural", or Items 23a CLIFTON AVE UNITED STATES 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 Divorced Specify: BLACK Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than the INDUSTRIAL LAUNDRY TECHNICIAN 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JONES THOMASON ပ STUS VIRGINIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILD CHERRY RD WINDSORMILL, MD21244 THERESA MCEachERN 20c Location - City or Town, State 20a. Method of Disposition 20b Place of Disposition (Name of Wood Lawre) Cemp reject 1 Surial 2 □ Cremation 3 □ Removal from State JUNE 28, 2017 WINDSUP MILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Lice 22. Name and Address of Facility
MILLER'S METROPOLITAN CHAPEL
1639 N. BROADWAY BALTIMORE, MD 23a. Part1. Emer the disease, or confdication. In a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rend acute /Medical Due to (or as a consequence of): Examiner Pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): $\widetilde{\mathcal{LO}}_{0}$ Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2**X**No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a, Certifier 1 🗫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) XIII petron DO059736 ma 20 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD LOURT ROAD INDETH WEST HOJ PITAL 5401 TT CATRICK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 2007 Registrar

			State of Maryland / De 1- For State Registra Amend #1 Per Phy G868 6/29/07 Q		ıd Mental Hygier		
3			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
No.	Physici /Medic		Zhuravskaya, Yudif Yudif	Zhuravskaya	4	Day Year 5 2007	7: 40AM
	Examin		4a. Facility Name (If not institution, give street and number) HOWAYD County General Hospital	4b. City, Town, or Location of E	Death 4	4c. County of Death	el
150	Funeral Director		5. Social Security Number 031-74-5314 6. Sex 1 □ M 2 □ F 87 Yrs	Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Yea 09/27/191)	ar) Cour	place (State or Foreign ntry) EKISTAN
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		[.	10d. Inside City Limits
	Maryla f sho	ō					1 □Yes 2 No
	the 1 28a- notifi	Director	MD HOWARD COLUM 10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	
	h with	al Di	7080 CRADDLEROCK WAY #212	21045		U.S.A.	
	ems ser mu	Funeral		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - Americ Black, White,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 ☐ Yes 2(X) No Specify:	, , , , , , , ,		WHITE
2-0	72 ho 'natuı dica	Completed	(Specify only highest grade completed) I (G	cedent's Usual Occupation ive kind of work done during most o	f working 16b.	Kind of Business/In	dustry
121	within ene. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) ICIAN		MEDICAL	
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Name (First, Middle, Maide	MEDICAL len Surname)	
Maryland	2 should be filed w n and Mental Hygie is marked other ti raumatic event, th	To Be	JOSEPH ZHURAV	SKY RACH	AEL	GLUB/	Д
lary	2 shou and ∿ is ma			ailing Address (Street and Number of			
≥,	1 and 2 Health Iem 27 i			WOODGATE COURT			
lore	it of H		1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State	sposition (Name of crematory or other place)		Location - City or To	
Baltimore,	it. Pa Irtmer Irtant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	SHAAS CEMETERY 00 22. Name and Address of Facility			
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.			8900 REISTERSTOW			
	518.		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as ca	rdiac or respiratory arrest,		Approximate Interval Between
N	Physician		Immediate Cause (Final disease or condition SeP5/5				Onset and Death
4	/Medical Examiner		Due to (or as a consequence of):	a k			
	Ela ³	7	Sequentially list conditions.				
i	uted 1 ansit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events				
o O	exection and and rial-tra	Еха	resulting in death) Last C. Due to (or as a consequence of):				
8760,	cate be executed ohysician and the burial-transit	dical	d				
9	death certifica e attending ph id for use as t	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			001 P-1(1-1)	
Box	atten for us	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	Day Year
P.O.	0 00 0	hysi	1 ☐ Yes 2 ဩ No 9 ☐ Unknown	(1)			
o, D	law requires that the das been signed by the 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ord	equire en sig	led k			1 Yes	2 No 3 Prot	bably 4 ⊠Unknown
ecc	law r las be	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E E	Physician: The law r this certificate has t ral director, page 2 s				performed? 1□ Yes 2☑		2 ☐ No
Zit.	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Other	Death (Check only one)		
ō	Physer this	1: To	27. Manner of Death 28a. Date of Injury 28b. Tim	tion old box	ng Home 5 ☐ Residence 28d. Describe how in		fy)
on	Attending Frideath. ector After by the funer	tior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injui	ry Work? M 1 ☐ Yes 2 ☐ No			
Division or Vital Records,	or Attendation description of the first of t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Str	and Number or Run ate)	al Route Number,
	Ital or Irs afe ral Dir Iled i	Cer					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director After th completely filled it by the funeral	edical	29a. Certifier (Check only one) 1 ▶ Certifying Physician: To the best of my knowledge, do 2 ■ Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death	occurred at the time, date a	and place, and due t	to the cause(s)
	To the h within 24 To the F complet	Me	29b. Signature and title of certifier	29c, License number	29d. [Date signed (Month,	Day, Year)
			Drown X/Mmax	D006034	S Ju	ne 23, 2	00/
	Ì		30. Name and address of person who completed cause of death (Item 23a) (Type Karen Ahmad, \$0724 little f	atuexant Parkway,	Columbia	Mb. 210	44.
	Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Tyl (Macr. Ahmad, 1724 Little 31. Date filed (Month, Day, Year) 32. Registrar's Signature	all of			

7-04678 Ianuel D Gonza			or Print in Black of Maryland / De		Health		Hygiene		7 210
		Ponintror		ertincate or	Deatti		Reg.	No.	3. Time of Death
Physicia Medical Examin	in/ ner	1. Decedent's Name (First, Middle, La: Manuel D. Gonzales Arr Manuel de Jesus	ador Consales Amad	lor			Month E June 18, 20		2210 hrs
		4a. Facility Name (if not institution, gir CSX railroad tracks	ve street and number)	4	b. City, Tov Laurel	wn, or Location of De	ath	4c. County of Deat Prince Georg	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	rs. last birthday)	If Under	1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	
Director			M 2 F 41	Yrs.	Months	Days Hours N	Dec_26,	Forei Co 1965 Hong	gn puntry) duras
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Location	on				10d. Inside City Limits
A .4									1 Yes 2 X No
yłanc ryłanc a-f sh	홠	MD Prince G 10e. Street and Number	eorge's	L	aurel 10f. Zip C	code	100	. Citizen of What Cou	Intry?
th the Maryland 23a or 28a-f sho	Director						ше	nduras	
with the standard stands	اچ	8826 Hunting Lan 11. Marital Status	e #004 12. Was Decedent Ever in	n U.S. 13. Wa	207	08 of Hispanic Origin?			rican Indian, Black,
eath v item:	Funeral	1 X Never Married 2 Marrie	d Armed Forces?	If Ye	es, specify	Cuban, Mexican, Pue	erto Rican, etc.)	White, etc.	
fler d f", or		3 Widowed 4 Divorce	1 Yes XX N d If Yes, Give Year or Dates:		Yes 2	No specify: Ho	nduran	SpecifyHispa	nic
215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene riked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	d by	15. Decedent's Education (Specify of				ccupation (Give kind ng life. DO NOT use		16b. Kind of Business	
72 hs	휼	Elementary/Secondary (0-12)	College (1-4 or 5+)	duning in	OST OF WORK	ng me. DO NOT use	retired)		
5-003(ed within tygiene other the	Completed	6		Construc	tion W			Constructio	n
15-0C filed wit Hygien d other		17. Father's Name (First, Middle, Las	t)				ame (First, Middle, Ma	aiden Surname)	
21215-0036 and be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	UNKNOWN Gonzalez Am 19a. Informant's Name/Relationship (10h Mailine	Address	Elena I		er, City or Town, Stat	e Zin Code)
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	٩	Olvin N. Rodriquez							0, 24 0010)
and 2 lealth tem 2 traur		20a. Method of Disposition	/Friend	0b. Place of Dispos	ition (Name		11e, GA 3050 Date	20c. Location - City o	r Town, State
more Pages 1 nent of 13 ant: If i		1 Bunal 2 Cremation 3	XX Removal from State	crematory or oth nta Ana de		re	1	holutokala U	and was
altimore, mit Pages I ar partment of He portant: If ite		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	y:					holutekak, H	
Balti permit Departin Imports		120ha V.12 / Oct.	1164.1	-00	** *	Fra	ancis J. Col	lins Funeral	Home, Inc.
Physician		23a. Part I. Enter the disease, or com	plications that caused the de	eath. Do not enter the	he mode of	dying, such as cardia	ac or respiratory arres	ring, MD 209 st, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on a Immediate Cause (Final disease	a Multiple injur	ries					Death
aminer		or condition resulting in death)	Due to (or as a consequent						
	پ	Sequentially list conditions,	Due to (or as a consequent	an of):					
	ij.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	de oi).					
B	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):					
executed ian and ial - transit	ical		d						-
O, s be ex sician burial	edic	X UNPENDED	X AMENDED , 27,28a	-f, perME,	3870 , 8	3/16/07 TT		Lood Date of delive	
30x 68760, death certificate be e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	oregnancy	etal death	3 Ectopic pre	egnancy	23d. Date of delive Month	ry Day Year
x 6 h cert tendir use a	icia	past 12 months?	4 Pregnant at time of	of dooth	her (Specia	fy)			
Bo e deat the at	hys	1 Yes 2 No 9 Unknow	9UIKIIOWII				Di Di Ma	1	- the same of doubte
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	þ	Part II. Other significant conditions	s contributing to death but r	not resulting in the t	underlying o	cause given in Part I.		2 ✓ No 3 Pr	o the cause of death? obably 4 Unknown
ds, squires	- 73								autopsy findings available
COF law re has b	nple						autops perform	ned? death?	
tal Rection: The certificate ector, page	Co					D D	1 Yes 2	No 1 ✔	Yes 2 No
ital ician: s certi	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		6.Place of Death (Ch		Residence 6 🗸 Oth	er: Scene
fV Phys er this	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		Bc. Injury at Work?		ow injury occurred	CI. COCIIC
nding rding rh. r. Aft	ion:	1 Natural 5 Pending	(Month, Day, Year)		· ·	1 Yes 2 y No	gubioct w	as struck by	a train
isio	icat	2 X Accident Investiga	28e Place of Injury	9:59 pm At home, farm, stre		21	Dubject we		Rural Route Number, City
Div tal or rs afte al Dir	Certification:	3 Suicide 6 Could no determine	ot be	lroad tracl	_		or Town, St	_{ate)} oad Tracks L	aurel. MD
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been sempletely filled in by the funeral director, page 2 should	CC	29a. Certifier 1 Certifying Phys	cian: To the best of my know	wledge, death occu	rred at the t	ime, date and place,	and due to the cause	e(s) and manner as st	ated.
o the lithin 2 in the limplet	Medical	one) 2 Medical Examin	er:On the basis of examinati	on and/or investiga	tion, in my	opinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
E-2E-8	Me	29b. Signature and title of certifier	/h.		29c.	License number		29d. Date signed (A	fonth, Day, Year)
		1) I de	X /U			O.C.M.E.		June 19, 2007	
,		30. Name and address of person wh	1		-	- 1	0.400:		
			sistant Medical Exami		n Street	, Baltimore, MD	21201		
S Regis	tate	31. Date filed (Month, Day, Year) 2	007 32 degistrar's Sig	gnature	AL.				
100015	11.1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04693 State of Maryland / Department of Health and Mental Hygiene Robbie Rhiannon Brewer Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 19, 2007 Year 1312 hrs Medical Examiner Robbie Rhiannon Brewer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silverspring 8040 13th Street 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1982 Texas OCT 27, Country) Director 24 1 M 2 XF 225-47-5445 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County Yes 2 X No s 23a or 28a-f show : e notified at once. Springfield Virginia Fairfax Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 22150 7425 Nancewood Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 2. Was Decedent Ever in U.S. must be White, etc. or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Caucasian f Yes, Give Year Yes 2 X No specify: Divorced Widowed traumatic event, the Medical Examiner "natural", ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 1
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "
injury or other traumatic event, the Medical. Veterinary Assistant 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth L. Thomas Brewer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11229 September La., Fairfax Station, VA 22039 9 Elizabeth L. Thomas / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Fairfax, Virginia 06/25/2007 Fairfax Memorial Pk. Other Specify Donation 5 22. Name and Address of Facility
Fairfax Memorial Funeral Home 21. Signature of Funeral Service M00956 9902 Braddock Rd., Fairfax, VA 220 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follows. Let only an account of the contract of the c Approximate Interval Physician Between Onset and failure. List only one cause on each line /Madical Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial -.28a-f. perME. g869. 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown è Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? has 1 🗸 Yes ✓ Yes 2 No this certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ Nursing Home 5 Residence 6 Other: Scene examiner? DOA Inpatient 2 FR/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natural 5 Pending unk Fnd 6/19/2007 FNd 12:45 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City

Division of Vital Records, P.O. he Hospital or Attending Physician: Ti in 24 hours after death. he Funeral Director: After this certifica pletely filled in by the funeral director, pa To the

3

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 6 X Could not be Suicide (Specify) Silver Spring, MD found in motel room Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

O.C.M.E.

June 20, 2007

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Day Year State 2007 Registrar

			1 - State Registrar		artment of Health and latificate of Death	Mental Hygier	C. 1.2	21077
ı	Physic /Medi		1. Decedent's Name (First, Middle, Last) Dorothy J. B	ennett		2. Date of Death Month	Day 14 Year 7	3. Time of Death 8130 pm
	Exami		4a. Facility Name (If not Institution, give street an		4b. City, Town, or Location of Death		4c. County of Death Frederic	K
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 W Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 07/13	9. Birthpla Countr Mar	ce (State or Foreign y) aryland
	th the Maryland or 28e-f ehow	Director	10a. State 10b. County Maryland Washington 10e. Street and Number	10c. City, Town or Lo	erstown 10f. Zip Code	10g. (100	d. Inside City Limits 1 Yes 2 No y?
5-0036	within 72 hours atter death with the Maryland ane. than "natural", or items 23a or 28e-f ehow ta Medical Earning trivial be invitibled at	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2X No	21740 Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	USA 14. Race - America Black, White, et Specify: Whit	.
7	vithin 72 ho ne. hen "netu	Completed		ited) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Indu	stry
land 21	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It a Mi	To Be Cor	10 (17. Father's Name (First, Middle, Last) Harold S. Near) Ноп		me (First, Middle, Maid	Her own h	ome
, Maryland	12 g = g	F	19a. Informant's Name/Relationship (Type, Prince Clara J. Jamison - De	consultar la consulta	Clara Ig Address (Street and Number or Re Salem Avenue. Ha	ural Route Number, Cit		
Baltimore,	permit. Pages 1 ar Depertment of Hea Important; if item eny injury or othe pncs.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee	from State 20b. Place of Dispo cemetery, crer Rest Have	sition (Name of natory or other place) en Cemetery 6/1 Name and Address of Facility 10 15 E. Wilson Blvd	8/07 Ha	gerstown, l meral Home	Maryland
	Physician /Medical		resulting in death)	hat caused the death. Do not ent on each line.			í	Approximate nterval Between Onset and Death
8760,	Examment and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Diayctes M e to (or as consequence of): CEVE D/O VASCUL e to (or as a consequence of):				tears.
P.O. Box 687	Attending Physician: The law requires that the death certificate be executed refath. relath. ector: Atter this certificate hes been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?		Detopic pregnancy Other (specify)		23d. Date of deliven	, yay Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	
Vital Records,	The law receive hes bee	Completed				24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of
Division of Vita	ttending Physician: 1 death. ctor: Atter this certitical y the funeral director, p	atlon; To Be	2 Accident investigation	1 Inpatient 2 ER/Outpatien Date of Injury Month, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Wursing H	ath (Check only one) lome 5 Residence 28d. Describe how in		
Divis	To the Hospitel or Attent within 24 hours after deatl To the Funeret Director: completely tilled in by the	I Certification;	4 Homicide	Place of Injury - At home, farm, stripulding, etc. (Specify)		City or Town, Sta		
	To the Hos within 24 ho To the Fun completely	Medical	Check only 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or in manner stated.	occurred at the time, date and place restigation, in my opinion, death occu-	29d. I	and place, and due to t Date signed (Month, D	he cause(s)
-			30, Name and address of person who completed	cause of death (Item 23a) (Type,	0 00 6 2223	•	6/15/07	
فد	H - /	te	30. Name and address of person who completed PLAYECN BOLARUM, M. 31. Date filed (Month, Day, Year)	D 196 THMAS. 32. Registrar's Signature	TOUTHOUSEN DRIVE,	SUITE # 23	10, trepeu	(CE, MD 2170,
	Registr		JUN 18 2007	Brown A. A.	and)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Buakler Month 2007 15:51 JUNC JOHMAN 4a. Facility Name (If not institution, give street and number)
The Johns Hopkins Hospital 4c. County of Death 4b. City, Town, or Location of Death Baltimore City BaHimare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 2 □ F Yrs. 87 Oct 9 1919 Maryland 216-18-3141 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a, State 10b. County Maryland Calvert Huntingtown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1290 Solomons Island Road 20639 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give ∠ Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 entrepreneur mobile Home Park owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alvin T. Buckler Lilly Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. Buckler- wife 1290 Solomons Is. Rd. Huntingtown MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Cemetery June 15 2007 Prince Frederick MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic mD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Nours 23d. Date of delivery Month Day Year use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

600 North Walte Baltimore Manyland

June

Stuce

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

burial-transit

use as the

been signed by the should be detached

page 2

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

6

permit. Page Department of Important: If eny injury or once.

Physician

/Medical

Examiner

Director

To Be Completed by Funeral

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and teme 23 sor 28s-f ehow ant: If Item 27 is marked other than "natural", or Items 23s or 28s-f ehow

Baltimore, Maryland 21215-0036

other traumatic avent, the Medical Examinar must be notified at

Physician/Medical Examiner Be Completed by Medical Certification:

disease or condition resulting in death)	" JA22 Z	XNgrame			2 Nours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	tial pulmon	any fib	rosis	3 Week
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic pred			23d. Date of delivery Month Day Yea
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cau	use given in Part I.	23e. Did tobacco	o use contribute to the cause of deat 2 No 3 Probably 4 Unk 24b. Were autopsy findings ava-
- 11				performed? 1 ☐ Yes 2 ☐	death?
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpatient 2	ER/Outpatient 3 DOA	Other	ath (Check only ofte) fome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be determined		ome, larm, street, lactory,	office	28l. Location (Street City or Town, Sta	and Number or Rural Route Number

State Registrar

29b. Signature and title of certifier

JUN 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christiapher Klaban off, The Johns Hopkins Hospital, 32. Registrar's Signature

Medical Doctor

31. Date filed (Month, Day, Year)

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

death.

29c. License number

Pez - 000

ason A. Barnes		State Registrar	of Maryland /		ent of Health ate of Death	and Ment		eg. No.	7 10 11 17
Physiciar	n/	Decedent's Name (First, Middle,La	th Day Year	3. Time of Death					
Medical Examin		Jason A. Barn 4a. Facility Name (if not institution, gi			4h City To	wn, or Location o	June 20, 2	4c. County of Dea	1150 hrs
		1916 Pump Handle Cour	· ·		Crown			Anne Arund	
Funeral Director			7. Age	(In yrs. last bir 27	thday) If Under Months Yrs.	1 Year If Under Days Hours	th(MM/DD/YYYY) 9. I For 3/1980	Birthplace (State or eign Washington Country) <u>C</u>	
THE RESERVE TO THE RE	-	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
*	ا ة	MD Anne A	rundel		C	rownsvil	le		1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number			10f. Zip (1	0g. Citizen of What Co	ountry?
ith the		1916 Pump Handle	Court 12. Was Decedent E	ver in IIS	13 Was Deceden	21032	in? (Specify Yes or No	USA	erican Indian, Black,
72 hours after death with the Maryland n "naturid", or items 23a or 28a-f she at Examiner must be notified at once	Funeral	1 X Never Married 2 Marrie	Armed Forces?	ζ _{No}			Puerto Rican, etc.)	White, etc	•
s'after o	by F		d If Yes, Give Year or Dates:		1 Yes 2			Specify:	White
2 hour: "natu	ge-	15. Decedent's Education (Specify (Elementary/Secondary (0-12)	only highest grade comp College (1-4 or 5+		Decedent's Usual O during most of work			16b. Kind of Busines	ss/Industry
1036 vithin 72 ene. er than Medical	Completed	12	-		Lands	caper		Laı	ndscaping
I	ခ် မြ	17. Father's Name (First, Middle, Las	,				s Name (First, Middle,		
D 2121; should be fil and Mental F 7 is marked natic event,		Donald Anthony 1 19a. Informant's Name/Relationship (19	b. Mailing Address		rie Marie l berorRumalRouteNum		ate, Zip Code)
Z pd 2		Carrie Marie Ko	rolewski/Mo		1916 Pum		Court, Cr		
Baltimore, permit. Pages I ar Department of Hes Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3	June 26,	20c. Location - City					
litim nit. Pag artmeni ortanti ry or o	ŀ	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		2007	Annapoli				
Balti permit. Departi Imports injury o	J	23a. Paryl. Enter the disease, or com	24		Barran 495 Gov	.co & S Ritchi	ons, P.A. Le Hwv. Sev	. Severna verna Park	Park F.H. MD 21146
Physician / /Medical	4	failure. List only one cause on a	each line.				ardiac or respiratory an	est, shock, or heart	Between Onset and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)	Narcotic int		on and cocai	ne use			Death
		Sequentially list conditions,	4						
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseq	uence of):			5 11 1		
Lingit ted	Exal	events resulting in death) Last	Due to (or as a conseq	uence of):					
50, te be executed tysician and bunal - transit	Medical	X UNPENDED	AMENDED 5.1	er fh	g872 10 –9	97 Y F			
Box 68760, a death certificate but the attending physical for use as the but	ĕ.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy				23d. Date of deliv	
Sox 6876 leath certificate e attending phy for use as the	cial	past 12 months?	1 Live birth 4 Pregnant at ti	me of dooth	Fetal death Other (Special		pregnancy	Month	Day Year
. 8 . 8 .	Physician/N	1 Yes 2 No 9 Unknow Part II. Other significant conditions	a Olikilowii	hut not requitir	es in the underlying o	auso siven in Re	et 23e Diet	ohacco use contribute	to the cause of death?
P.O.	اھ	rart II. Other significant conditions	contributing to death	but not resulti	ig in the underlying t	ause giveiriii Fa			Probably 4 Unknown
rds, P.C	etec						24a. Was		autopsy findings available to completion of cause of
tal Reco	Completed							rmed? death	?
tal	Be C	25. Was case referred to medical examiner?	Hospital:			Place of Death (
of Vital I	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		Outpatient 3 DC Time of Injury 28	A Other A	Nursing Home 5 28d, Describe	Residence 6 Ot	her: Scene
- = `~='	ertification:	1 Natural 5 Pending	(Month, Day, Yea	er)		1 Yes 2 X		non injury seconds	
Division rate of a strength rate of a strength. al Director: A led in by the fu	20	2 Accident Investigat 3 Suicide 6 X Could no	t be 28e. Place of Inju	ry - At home, f	arm, street, factory,	office building, etc			Rural Route Number, City
y frie	ပြု	4 Homicide determin	(0) 30,7) 100	ınd in re					Crownsville, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	ı۵ ا	(Check only one) 1 Certifying Physical One) 2 Medical Examination	cian: To the best of my er:On the basis of exami	knowledge, de ination and/or	eath occurred at the t investigation, in my o	me, date and pla pinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
wit Com	ĕŀ	29b. Signature and title of certifier	and mariner stated.		29c.	License number		29d. Date signed (i	Month, Day, Year)
		Carol +	Halla	~		O.C.M.E.		June 21, 2007	
		30. Name and address of person who Carol Allan, MD Assist	completed cause of deant Medical Exam		Penn Street, B	altimore. MD	21201		
Sta	te	31. Date filed (Month, Day, Year) JUN 2 6 21		Signature					
Registra	ar	JUN 2 6 21	JU/ Stores	K	sperker				
DHMH 17 Rev 1/200	1			OF	RIĞINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:04 PM IUNE 17 2007 Lee Carmel Carol /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown Washington Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🔀 F 166-34-5959 66 Director July 17,1940 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 10918 Allen Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School/ Education 12 Teacher 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Feeley Isabel Hazel Mulhollen ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10918 Allen Avenue Hagerstown, Maryland 21740 Carmel (Husband) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr G. Edward 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory 6-19-2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Osborne Funeral Home P.A. 425 South Conococheague St. Williamsport, Maryland 21795 Tuneral Service Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC Physician Y5ARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No detached Records, P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ þe 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performed 2□ No certificate ISCHEMIC COUTIS CELLULITIS 1□ Yes 2 No 1 ☐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

0H-8

State Registrar

31. Date filed (Month, Day, Year)

JUN 19 2007

704

PAMELA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Sperke

65R570WN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Maria Bessie Calandrelle JUNE 2007 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 010-24-5138 1 ☐ M 2X F Yrs. 75 01/17/1932 MA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 US 19828 Bennie Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "naturar," or iten any injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify. ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret (unk) Gray Matthew (unk) Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Calandrelle, Jr./Son 19828 Bennie Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/20/2007 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2-3 hom اد /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown ģ signed k 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 Pulmy Dine 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Untilia 2: mich aliti 24a. Was an autopsy performed Anteno scente Cendro Varial 2 4NO Division or Vital Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Function (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the vithin 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 18019 (Det M) JUNG 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740

5H-5

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

JUN 18 2007

VASANT DATTAMD

32. Registrar's Signature

240

MAGERSTOWN

ORIGINAL

MILL ST

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			achies vie Fe
State of Maryland	Department of H	lealth and Me	ental Hygiene

1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Harold Fisher Clark June 14, 2007 11:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (State Country) | August 26 1926 | Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1**X** M 2□F Yrs 212-24-7471 80 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow other traumatic ayant, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 154 N. Artizan U.S.A. or Itams 23a 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelin and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any Injury or other traumatic avant. The second once. Black, White, etc. Affried Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Truck Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lloyd Clark Nellie Fisher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Poffenberger / Daughter P.O. Box 624 Falling Waters West Virginia 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 6/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPRATION PNEUMONIA **Physician** 12 HOURS /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): ettending physicien for use as the burier Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ PARKINSONS ENDSTAGE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Pis After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral C 1 Cartifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and in a time as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medicai (Check only one) tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Fine 15, 2007 completed cause of death (Item 23a) (Type, Print) MASITISAN WILLIAMSPORT, MD JH 2+1 Howe 31. Date filed (Month, Day, Year)
JUN 18 2007 32. pgistrar's Signature State Registrar

07

07-04427		Plea	se Typ	e or Print i	n Black	Indel	lible In	k. Ens	sure	All Co	opies	Are Le	gible	€.		
Herbert Norman (er For State	St	ate of Maryl	and / De	partm	nent of	Health Death	and	Menta	аі пуд			· -		7 210
	R	egistrar . Decedent's Name (Eiret Midd	a Lact)		,ei uiic	ale of	Death			2.	Date of Dea	eg. No.		3.	Time of Death
Physicial Medical Examin			bert	Norma:	n Coo	oper	:					Month June 9, 2		Year		1941 hrs
-t	4	a. Facility Name (if r	not institutio	n, give street and r				b. City, Tov Dunkirk		cation of	Death		- 1	c. County of I Calvert	Death	
Funeral		5. Social Security Nur		6. Sex	7. Age (In y	rs. last bi	irthday)	If Under		If Under	_	8. Date of B	irth (MM/	(DD/YYYY)	9. Birthp oreign	lace (State or
Director		533-30-1	513	1 X M 2 F	8	4	Yrs	Months	Days	Hours	Min.	05-04	_192		Count	ry) Canada
		Jsual Residence of E	Decedent 0b. County		10c. (City, Tow	n or Locat	ion							10	Od. Inside City Limits
nd show any				Arundel					iend	dship)					Yes 2 X No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Num 6522 Wil		beog				10f. Zip C	758				10g. Cit	izen of Wha USA	t Country	f?
ith the 23a or notifi	a D	11. Marital Status	.5011 1		ecedent Ever	in U.S.	13. Wa	s Decedent	of Hisp	anic Orig	in? (Spec	cify Yes or N	lo-	14. Race -		n Indian, Black,
death w	Funeral	1 Never Married		Married Armed	Forces?		If Y	es, specify	Cuban,	Mexican,	Puerto Ri	ican, etc.)		White,		4
after al", o	ð.	3 Widowed		vorced If Yes, Give Y or Dates:		d) 1404		Yes 2			and of wo	rk done	16b.	Kind of Busi		
hours 'natur Exam	ted 1	15. Decedent's Edu Elementary/Secon			(1-4 or 5+)	168	during m	ost of worki	ng life.	DO NOT	use retire	d)	105.			
36 hin 72 e. than '	ple	9	idary (0-12	,	(1 10.0)		carpe	enter/							truc	ction
5-00 led witl tygien other	Completed	17. Father's Name (F	First, Middle	e, Last)					1		's Name (First, Middle	, Maide	n Surname) Lane		
121 d be fil ental l arked	Be	Arthur 19a. Informant's Nan	no/Deletion	Cooper		- 1	19h Mailin	a Address	(Street				umber, (City or Town		Zip Code)
D 2 should and M 7 is m	٩	Alva Rhea						Wilso						MD 20		
e, M and 2 Tealth item 1	1	20a. Method of Disp	osition			20b. Plac	e of Dispo	sition (Name	e of cerr	netery,		Date	200	. Location - 0	City or T	own, State
nord ages I ant of I nt: If		1 X Burial 2 Donation 5		1	I from State		em UM	Churc	ch C	em.						lle, VA
altin mit P partme portan ury or	9	21. Su nature of Fur	neral Service	e Livensee										ral Ho		
E P E E		23a. Part I. Enter he	a/	hell	are	In the Da	8:	325 Mt	H dyang	armo	ny La	ne, C	W1De	gs, MI) 20 rt	Approximate Interval
Physician /Madical		23a. Part I. Enter the failure. List only	e disease,fo y one caus	e on elarch line.) not enter	the mode of	uying,	30011 00 0	,a. a. a. a.	, copiler, y	,			Between Onset and Death
.xaminer		Immediate Cause (For condition resulting			s a conseque										\neg	
1		Sequentially list cor		b							_				-	
	ine	if any, leading to im	rlying Caus	е	is a conseque	nce of):										
cuted tnd transit	Examine	(Disease or injury the events resulting in o			is a conseque	ence of):	_									
ar ar	<u>_</u>	UNPENDED		AMENDE	:D									- <u></u>		
'60, ate be physici he buri	Physician/Medic	IF FEMALE:		Abo	es, outcome o	f pregnar			2	Catan		201	7	23d. Date of Month		ay Year
Box 68760, e death certificate be the attending physic ed for use as the bur	ian/	23b. Was decedent past 12 months	pregnant ir ?		ve birth egnant at time	e of death		etal death Other (Spec	3 (cifv)	Ectop	ic pregnai	icy		WORK		
30x death	ysic	1 Yes 2 1	No 9 t		nknown											b - seven of donth?
	by Pt	Part II. Other signi	ficant con	ditions contributir	ig to death bu	t not resu	ulting in the	underlying	cause (given in P	Part I.					he cause of death? ably 4 Unknown
lS, F quires en sigr	ted											24a. W				topsy findings available
cord aw rec has ber 2 shou	Completed											pe	itopsy erformed	1? 6	death?	ompletion of cause of
Rec The ficate	S								26.Place	e of Death	n (Check o		es 2	No 1	✓ Ye	5 2 10
ital sician: s certi irector	Be	25. Was case refer examiner?		Hospital:	Inpatient	2 E	R/Outpatie		OA	Other ₄		g Home 5	Res	idence 6	✓ Other	: Scene
ision of Vital Estending Physician: r death r ector: After this certification, by the funeral director,	<u>د</u>	1 ✓ Yes 27. Manner of Dear	2 No	28a. [ate of Injury	2	8b. Time o	f Injury	28c. Inju	ry at Wo	rk?			injury occurr		
On (endin eath. or: A	tion	1 Natural 2 Accident		enuling	lonth Day,Year) 9, 2007		1934 hrs		-	Yes 2 ▼	No					I De la Maria Cita
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. After this certificate has been signed by sely filled in by the funeral director.	Certification:	3 Suicide	6 C	ould not be 28e.	Place of Injury				, office I	building, (etc.	28f. Location	on (Stree n, State	et and Numb :) Road, Dun	erorRu kirk Mo	ral Route Number, City
Dir To the Hospital G within 24 hours at To the Funeral E completely filled	Cer	4 Homicide		Physician: To the	cify) Major				timo d	late and r						
To the Hos within 24 h To the Fur completely	ical	(Check only one)	Certifying Medical E	xaminer: On the ba	asis of examin	nowledge ation and	/or investi	gation, in my	y opinio	n, death o	occurred a	t the time, d	late and	place, and	due to th	e cause(s)
To the with the to	Medical	29b. Signature and		and mani	er stated.					se numbe						nth, Day, Year)
	=	0.19	Spella	11 nan				1	O.C	.M.E.			J	une 10, 2	2007	
11		30. Name and add	ress of per	son who completed	cause of deat	th (Item 2	(3a)									
		Pamela E.			ant Medica	l Exam	niner	111 Penr	Stree	et, Balti	imore, N	VID 2120	1			

State 31. Date filed (Month, Day, Year) 18 2007 Registrar

amend line 12 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 6/19/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** ROWDY Ames 2001 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner +PNULD TURECARE if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Nov 12 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1**X** M 2□ F Yrs. 219-16-0328 81 1925 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Exercitor must be outilined at Y Yes 2 □ No Maryland Anne Arundel Annapolis Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 518 Fifth St. Items 23a 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1944 filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1946 1 ☐ Yes 2 ☐ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States d Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Naval Academy lyr Cook it of Health and Mental Hygi. If item 27 Is marked other or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be intented to the Mental I would Mental I should the marked o William O. Crowdy Mary Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James O. Crowdy Jr. (Son) 1784 A Belle Dr. Annapolis, Md. 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Maryland Veteran 6-20-07 Crownsville, Md. WmNameRecome of SacilSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Larry D. feese MO & 83 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MeTASTAITC

Due to (or as a consequence of): **Physician** YORKS PROSTATE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? STAGE ROWAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should CHOLECYSTI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DОА 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. of Vital Records, P.O. Division within 24 hours after death. To the Funerel Director: A

completely

filled in by

cal

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month,

29b. Signature and title of certified

6 Could not be determined

char

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

State Registrar

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ETERANS HIGHWAY MILLENSVILLE MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 5:27 a M Thomas Joseph Davin, Jr. June 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 F 500-32-2822 76 Director 14. Missouri Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director Maryland Montgomery Kensington or items 23a or 28a-f 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 4612 Saul Road 20895 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ¾☐ No SpecifyWhite þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Attornev Federal Government Law permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Joseph Davin Loretta Veronica Meyers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley H. Davin/Wife 4612 Saul Road, Kensington, Maryland 20895 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signatura f Funeral Service Ocensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastrointestinal Hemorrhage 3 Days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Dunknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Acute Myeolcytic Leukemia, Thrombocytopenia 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 X Natural 5 □ Pending 1 □ Yes 2 □ No investigation 2 Accident To the Hospital or Attend within 24 hours fer death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 法文CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eric Park, MD

31. Date filed (Month, Day, Year)

JUN 15

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32/Registrar's Signature

5:27am

DHMH 17 Rev 1/2001

State

Registrar

9901 Medical Center Drive, Rockville, MD 20850

29c. License number

D60117

29d. Date signed (Month, Day, Year)

June 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

atalie Dawn Dub	1 F	State of Maryland / Department - For State Certificate legistrar		Reg. No. 2007 210
Physiciar Medical Examin	er	1. Decedent's Name (First, Middle,Last) Natalie Dawn DuBois	-	2. Date of Death Month Day June 11, 2007 3. Time of Death 2252 hrs
		4a. Facility Name (if not institution, give street and number) 9517 Dunbrook Court	4b. City, Town, or Location of Dea Gaithersburg	Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 M 2 F 30	y) If Under 1 Year If Under 24H Months Days Hours Mi Yrs.	- Tanina
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Lim
with the Maryland 11s 23a or 28a-f show be notified at once.		Maryland Montgomery Mo 10e. Street and Number 9517 Dunbrook Court	ontgomery Village 10f. Zip Code 20886	10g. Citizen of What Country? USA
r death or iter must	by Funeral	1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer Yes 2 X No specify:	rto Rican, etc.) White, etc. Specify: Black
5-0036 ted within 72 hours after tygiene "matural" (the Medical Examiner)	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind o ng most of working life. DO NOT use re Executive Assistan	retired)
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Francis X. DuBois 19a. Informant's Name/Relationship (Type, Print) 19b. M	Pasc	me (First, Middle, Maiden Surname) caline Justin or Rural Route Number, City or Town, State, Zip Code)
re, MD s 1 and 2 sho f Health and If item 27 is er traumati		Pascaline DuBois/Mother 133 20a. Method of Disposition 20b. Place of Disposition 3 Removal from State crematory	09 Bea Kay Drive, sposition (Name of cemetery, or other place)	Silver Spring, MD 20904 Date 20c. Location - City or Town, State June 18,
Baltimore, permit. Pages 1 a Department of the Important: If ite injury or other the		4 Donation 5 Other Specify:	Heaven Cemetery 22 Name and Address of Facility Francis J. Collin 500 University B1	2007 Silver Spring, Mary as Funeral Home Inc.
Physician /Medical Examiner	1	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ter the mode of dying, such as cardiac	c or respiratory arrest, shock, or heart pproximate Inter Between Onset a Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisasse or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		
execut an and al - tra	Medical Ey	d d		
certifica	sician/I	FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 2 Pregnant at time of death 5 2 2 2 2 2 2 2 2 2	Fetal death 3 Ectopic preg Other (Specify)	gnancy Month Day Year
P.O. B es that the d	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
of Vital Records, ig Physichan: The law requiring the this certificate has been some all director, page 2 should	Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause death?
of Vital Recing Physician: The After this certificate uneral director, page	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Cheratient 3 DOA Other Nur	rsing Home 5 Residence 6 Other: Scene
ion of \text{tending Phy} eath. tor: After th the funeral	⊢ŀ			28d. Describe how injury occurred Subject hanged herself
Division Hospital or Attendi 24 hours after death. Fruneral Director: 1ety filled in by the fi	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, or Town, State) 9517 Dunbrook Court, Gaithersburg, MD
	Medical (29a. Certifier Check only one) Certifying Physician: To the best of my knowledge, death one) Medical Examiner:On the basis of examination and/or inverse and manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
7	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 12, 2007
	ŀ	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201	
Sta Registr	ite	31. Date filed (Mana Pay Yetz) 2007 32 Registrar's Signature	heeles	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 13, 2007 4c. County of Death NORMAN ALAN DAVIS SR. une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9348 Prince Colles 6-corpe's voad curla if Under 1 Year | If Under 24 Hrs. 8. 8. Date of Birth

Mynth, Day, Year)

JUNE 26 10 5. Social Security Number Sev . Age (In vrs. last birthday) **Funeral** 1**∑**M 2□F Days Hours Min 61 Director 201-34-6394 26,1946 PA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 'natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ▼Yes 2 No Funeral Director PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9348 CHERRY HILL RD. #705 U.S.A. 20740 Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be fled within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 4 COMPUTER TECH. UNIVERSITY OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ **JAMES** DAVIS CATHERINE GAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALESKA GREENE/DAUGHTER 3620 BOB HANNAH DR., LAWRENCEVILLE, GA. 30243 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HOMEWOOD CEMETERY 6-18-2007 PITTSBURGH, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5001 CLEVET AND AVE. RIVERDALE, MD. 20737 M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) enive Heart Dis **Physician** Arteriosal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for se a nonsequence of Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year the 9☐Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown has been si e 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□No 1 ☐ Yes 2 No 1 TYes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 1 5 2007

300)
32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 4:00 P M 6 17 Patricia DiPasquale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury 1310 Sylvia St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 ☐ M 2 ☑ F 8/2/1956 NJ50 Director 156-50-5710 Usual Residence of Decedent 42 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 1310 Sylvia St. 21804 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mental Health Care Mental Helath Advocate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Durek Edward Reitz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Rev. Craig DiPasquale / Husband 1310 Sylvia St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memory Gardens 6/19/2007 Newark, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 23a. Port1. Enter the disease, or complication shock, or heart fallure. List only one cau Immediate Cause (Final METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examiner the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760. physician IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month Day Year in the past 12 months? 1 ☐ Yes 2 12 No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Ö 9∏Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of eause of death?

1 □ Yes 2 □ No 24a. Was an page 2 : performe 1□ Yes 212 No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Division 1 Natural 1 Yes 2 No death. 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN SHORE DR. SALISISVEY MD BA8

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JUN 18

			1 - For State Registrar		of Maryla	nd / Depa	artment rtificate			and M		Reg	ene 3. №2 ()	07	21090
Г	Physici	an	Decedent's Name (First, Middle		-1- DIT	EMBOOEN					2. Date of Month	Death	^{Day} 007	Year	3. Time of Death
J.	/Medi Examir		4a. Facility Name (If not institutio			ENBOGEN	4b. City, To	own or	Location o	of Death	Juile	14,		y of Death	8:13 A M
	Examir	ier	Holy Cross Hos	-					Spr					ntgon	
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1	Year Days	If Under:	24 Hrs. Min.	8. Date of	Birth Day,	9. Birthplace (State or Fore Country) Texas		
	Director		462-26-3407	1□M 2QF	8	2 Yrs.	I I I I I I I I I I I I I I I I I I I	Dayo	1100.0		June	6,	T925	Texa	1s′
	land II		Usual Residence of Decedent 10a. State 10b. County	,	10c. C	City, Town or Lo	cation								10d. Inside City Limits
	Mary Ff sh	to	Maryland Mont	gomery		Silver	Sprin	19							1 □Yes 2 No
	or 282	lrec	10e. Street and Number				10f. Zip (g. Citizen of		•
	ath wi	ral	1121 Universit	y Blvd.,	W. #20			209					Inited	Stat	es
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examinar must be notified at ODGs.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes	2₽SNo iive	1	Was Decede f Yes, specif 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Rican, etc.	No-		ck, White	ican Indian, , etc. nite
8	2 hour	ed t	15. Deceder	nt's Education		16a, Dece	dent's Usual	Occupa	ition			16	Sb. Kind of B	Business/Ir	ndustry
215	hin 72	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work DO NOT use	done d retired)	luring most	t of worki	ng				
2	ed wit	Con		4		H	omema!	ker					Own	Home	2
Baltimore, Maryland 21215-0036	wild be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Yosef Rot	,						r's Name	_	ldie, Ma	aiden Sumai	me)	
Jar	2 she nand resummersum	1	19a. Informant's Name/Relations				ng Address (p Code)
e,	1 and Health em 27 ther t		Joe1 Ellenboger 20a. Method of Disposition	ı, Son	20b.		Raphae sition (Name				comac) 208 0c. Location		own State
no	eges ant of it: if it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Julio	Place of Dispo			!	0611					
뵱	ourthur injur		21. Signature of Funeral Service		Mt	. Leban	on Cer						delph	1, MI)
ä	2 5 E 8				> .		54 Can							DC	20012
	Physician		23a. Part Y. Enter the disease, o shock, of heart failure. List Immediate Cause (Final disease or condition	only one cause on	caused the decearch line.		_	, ,			or respirator	y arres	t,		Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):	PNE C	7,,0							0/0 - 1000
П	Cxammer		Sequentially list conditions,	D		ULBAR	PA	LS						- 4	MONTH
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conse	equence or):									
Ċ.	rate be executed thysicien and the burial-transit	Ехаі	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of):						-			
760,	te be ysicie ne bur	Cal		d											
89	artifica ing ph	Med	IF FEMALE:										-		
Box	law requires that the death centificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregi birth 2 □ Fe	tal death 3	Ectopic pre							ate of deliv	rery Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Preg 9☐Unki	nant at time of nown	death 5L	Other (spec	:rfy)				_			,
О.	s that ned by a deta	by Ph	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cau	ise give	n in Part I.		23e. D	id toba	cco use con	tribute to 1	the cause of death?
g	w requires to been signed should be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled be controlled by the controlled be controlled by the controlled	ed b									1	☐ Yes	2 No	3 Pro	bably 4 □Unknown
ဝင္ပ	ne law re has bee ye 2 sho	Completed									24a. W	has an utopsy	24b.	Were auto	opsy findings available ompletion of cause of
œ =	The ate h	Com										erforme	d? ONo	death?	2□ No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?			122		T 04-		of Death	Check or	ly one)			
o	Attending Physician: r death. sctor: After this certifice by the funeral director;	2	1 ☐ Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatien			4 🗀 190				ce 6 Ott		fy)
0	th. : After	tlon	1 Natural 5 Pendir 2 Accident investi	'9	of Injury oth, Day Year)	Injury	м 200	Unjury Work 1 □ Y	? ′es 2∐1		200. 005011	DO HOW	anjury occus	1100	
Division of Vital Records,	Atternation of the photograph	Certification:	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At	home, farm, str	eet, factory,				28f. Locatio	n (Stre	et and Num	ber or Run	al Route Number,
ā	tal or A	Cert	4 Hornicae	build	ling, etc. (Spec	any)					City or	rown,	State)		
	To the Mospital or Attending Phyitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Certifyir (Check only one)	ng Physician: To the Examiner: On the and ma	e best of my kr basis of examin nner stated.	nowledge, death nation and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, a	and due to to	he cau ne, date	se(s) and m e and place,	anner as s and due t	stated. o the cause(s)
	C D T	Σ	29b. Signature and title of certifie	1//	On	110			number			290	l. Date signe	ed (Month,	Day, Year)
•	>		Man 11	euna	KUL	MU		-91	453			J	une	14	100)
			30. Name and address of person		se of death (Ite	em 23a) (Type,	Print) GROV	- n	0 6	Pac b	VILLE	,	ain	200	(C)
	Sta	te	31. Date filed (Month, Day, Year)	32	Règistrar's Sigr	nature		_ 19	· V-		VILLE	. 6	710	-00	٥٠
	Registr		JUN 15	2007	yes to	y Aga	A. A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Frank Harlan Everly June 11, 2007 7:32 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Ctr. Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Oct. 15, 1929 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months 1**⊠**M 2□F 189-22-5367 77 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygelner. Insportant: It flem 7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Director MD Gambrills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2606 Chapel Lake Drive, Suite 308 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White by Specify: Korea 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Company Controller Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Watson Everly Pearl Ester Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louvenia Jane Everly/Wife 2606 Chapel Lake Drive, Gambrills, MD 21054 June 14, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛭 Other (Specify) Entonbuent 2007 Allison, PA Allegheny Mem. Park 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of uneral Service Licensee (dan 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner POV June Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ir as a nonsequence of): Examine the burial-transit Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical ast IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1□ Yes 2XNo Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ٥ After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide GertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title D41816 ハソ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solumens Is land RD. Annapolis 32. Refistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

JUN 1 4 2007

-Rark

		ot (O/ INDIO! CITY	yland / Depa		lealth and Mental	I Hygiene	e. 7 21092			
	Physicia /Medic	ın al	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Eschi	Ngen	2. Date Mon	3 11 0	ear 1-00 PM			
	Examin	er		er (In yrs. last birthday)	A If Under 1 Year	Cocation of Death nnapolis If Under 24 Hrs. 8. Date Hours Min. (Mor	4c. County of Déath Anne Arundel 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country)				
	Director	ľ	Total State	97 Yrs.		July	7 15, 1909	Washington, DC			
	with the Mary a or 28a-f sh be notified a	Director	Maryland Anne Arundel 10e. Street and Number 3392 Pocahontas Drive		10f. Zip Code	gewater 037	10g. Citizen of Wh				
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Married 2 □ Married 3 □ Married 2 □ Married 4 □ Divorced 1 □ Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:	etc.) Black,	American Indian, White, etc. White			
1215-0036	within 72 hou ene. than "natura hr M dical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	edent's Usual Occup e kind of work done DO NOT use retired Mechani	during most of working d)	16b. Kind of Busin	ness/Industry			
Maryland 21	should be filed withir nd Mental Hygiene. marked other than marke event, the M	To Be Co	8 17. Father's Name (First, Middle, Last) Ernest William Eschinger			18. Mother's Name (First, Emma Weisenk	perger				
	1 and 2 sho Health and I em 27 is me other traums		19a. Informant's Name/Relationship (Type. Print) Shirley Kalthoff/daughter 20a. Method of Disposition	3388	Pocahont	and Number or Rural Route as Drive Edg		yland 21037			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Ft. Line	22. Name and Addre	tory 6/15/200 ss of Facility John M of Gloucester	4. Taylor Fu				
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a	he death. Do not er				Approximate Interval Between Onset and Death			
68760,	ate be executed ysician and he burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):	97 y	nrs 1/ m	onths	10 Jeans			
O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transif	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome properties of the past 12 months? 4 □ Pregnant at 1 □ Unknown	2 ☐ Fetal death 3	☐Ectopic pregnand	у	23d. Date Mont				
ords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I. 23		oute to the cause of death? B Probably 4 Unknown			
al Reco	sician: The law r certificate has be rector, page 2 sh	Completed				10	performed de Yes 252 No 1	ere autopsy findings available ior to completion of cause of eath? Yes 2 No			
Division or Vital Records,	ing After	Medical Certification: To Be	25. Was case referred to medical examiner? 1	y 28b. Time Year) Injury	of 28c. Inju	ry at 28d. De rk?] Yes 2 □ No	Residence 6 Other	d			
Divi	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	al Certifi	4 Homicide determined building, etc	f my knowledge, de	ath occurred at the t	Cit	ty or Town, State) e to the cause(s) and man	iner as stated.			
	To the Ho within 24 h To the Fu completely	Medic	(Check only one) 2 Medical Examiner: On the basis of and manner stated title of certifier 29b. Signature and title of certifier			se number	29d. Date signed	(Mopth, Day, Year)			
	100hz.	ate		eath (Item 23a) (Type M D ur's Signature	e, Print)	M. CAnoline	ST- BA	Travane MD			
	Regist	rar	JUN 1 8 2007	m K	Sint.						

DHMH 17 Rev 1/2001

ORIGINAL

				Please 1	State of Ma								_	e.		
			For State Registrar		State of Mi	arylari				Death	wentai m	Reg. No	0.00	7	21093	
H,	Dhusisi		Decedent's Name (Fi	irst, Middle, Last)						2. Date of D	eath Da	y Y	ear	3. Time of Death	_
100	Physicia /Medic		Emma	Frma				T			Jun		1 20		1145 A M	_
X	Examin	er	4a. Facility Name (If not	_						Location of Deat	h		County of			
	Funeral	*	Washingto 5. Social Security Numb			e (In yrs.	last birthday)	If Unde	gers er1 Year	If Under 24 Hrs						
ü	Director		213-28-918	31	☐M 2131F	75	Yrs.	Months	Days	Hours Min.	Sept.	10 , 1		Coun Mary	land	
	pu >		Usual Residence of Dec	cedent b. County		10c City	, Town or Lo	cation						1	0d. Inside City Limits	_
	//anyla shov ed at	ō		Frederi	o.lr	1001 011		unswi	ole.						1⊠Yes 2□No	
	the 1 28a-	Director	Maryland 10e. Street and Number		CK		DI		ip Code			10g. Ci	tizen of Wha	at Coun	try?	
	h with	alD	701 Secon	nd Avenu	e				2	1716			Unite	ed S	tates	
	r dear	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Dec	edent of H ecify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	10-	14. Race - Black,			
36	s afte	by Fi	1 ☐ Never Married 3 ☒ Widowed 4 ☐		1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		1 □ Yes	2 X No	Specify:			Specify:	Wh	ite	
8	be filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	edb	15.	. Decedent's Edu	ucation		16a. Dece	dent's Us	ual Occup	ation		16b. k	(ind of Busir	ness/Ind	dustry	_
215	hin 72 e. an "n Medi	Completed	(Specify of Elementary/Secondary	only highest grad ary (0-12)	fe completed) College (1-4or:	5+)	(Give life.	kind of w DO NOT	ork done o use retired	during most of wo f)	rking					
7	led wi lygien ner th	S	8	-4 #4:J-H- (++4)				Art	ist	18. Mother's Na	mo (Eiret Midd	lo Maido	Art			_
and	0 = 0 %	Be	17. Father's Name (First Frederick								achel A		ŕ			
ary	2 should be f n and Mental P is marked of raumatic eve	٩	19a. Informant's Name		/pe. Print)		19b. Maili	ng Addres	ss (Street	and Number or R				ate, Zip	Code)	_
ž	and 2 alth a 27 is er trai		Colleen T	Cibbetts	/ Daught	er	701 \$	Secor	nd Av	enue B	runswic	k, M	arylar	nd 2	1716	
Baltimore, Maryland 21215-0036	of He of He If item or oth		20a. Method of Disposit		Removal from State	20b. F	lace of Dispo emetery, cre	osition (Na matory or	ame of otherplac	e) Ju	Date 1y 5,	20c. L	ocation - Ci	ty or To	own, State	
tim	: Pag tment tant: I		4 □ Donation 5 □	Other (Specify)	Ar1	ingto			m.	2007	Ar1	ingtor	1, V	irginia	_
Baj	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evonce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facili 1621 Opossumtow									tauffer					
			23a. Part1. Enter the d shock, or heart fa				ICK, F	lary	Approximate Interval Between	_						
	Physician		shock, or heart fa Immediate Cause (Fina disease or condition		ne cause on each I	ne. (0.	ee L	uno							Onset and Death	
	/Medical		resulting in death)		a. Due to (or as			- 0) (21 mon				\top		_
Н	Examiner	_	Sequentially list conditi	ions,	b. Ovon		SSTNI	salu	e 1	Mon	cy D	use	GSC			_
	ted sit	nine	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju-	ediate ng ury	Due to (or as	a conseq	uence or):				U					
Ć,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	_	c Due to (or as	a conseq	uence of):									_
160	eath certificate be e) attending physician for use as the buria			•	d											_
(687	The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE:													_
Вох	attend for us	ian/	23b. Was decedent pre in the past 12 mg	withs?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3[⊒Ectopic ⊒ Other (pregnancy	/			23d. Date (Month		ery Day Year	
o.	that the dened by the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	lo	9☐Unknown	it time or d	- J		зресну/							
٦,	s that ned b e deta	by Ph	Part II. Other significan	nt conditions co		-	ulting in the u	inderlying	cause giv	en in Part I.	23e. Die	d tobacco	use contrib	ute to tl	ne cause of death?	
ords	aw requires that s been signed t e should be det	ed b	Lett Lu	ng a	0/200	20)					1 5	Yes 2	2 □ No 3	☐ Prob	ably 4 □Unknown	
ecc	ne law re has be ge 2 sho	plet	ACUTE	newas	tal	ul					24a. Wa	topsv	pri	or to co	psy findings available mpletion of cause of	
E B		i o racina									pe 1□ Yes	rformed? 2□M		ath?]Yes	2□ No	
or Vital Records,	Physician: The rthis certificate ral director, pag	© 25. Was case referred to medical examiner? 1 □ Yes 2 □ No Other: 1 □ Mospital: 1 □ Mospital: 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nur								26. Place of De			л Пои	(0		_
	g Phys er this eral dir									4 LI Nursing	Home 5 ☐ Re 28d. Describ			· · ·	y)	-
ion	Attending r death. ector: After by the fune	2 Accident investigation M 1 Yes 2														
Division	or Atte ter de irecto n by th	tific	3 Suicide 6 4 Homicide	6 Could not be determined	28e. Place of in building, e	jury - At ho tc. <i>(Sp</i> ec <i>il</i>	ome, farm, st	reet, facto	ory, office		28f. Location City or 7	(Street a Town, Sta	ind Number te)	or Rura	al Route Number,	
Ω	Hospital or 24 hours afte Funeral Dir tely filled in	O	29a. Certifier 1	Cartifying Phy	/sician: To the best	of my kno	uulodaa daa	th occurre	ad at the ti	me data and plac	o and due to the	ne callee/	e) and man	207.20.0	tated	_
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical			iner: On the basis of and manner si	of examina										
	To the I within 2 To the I complet	Me	29b. Signature and title	e of certifier		_		2	9c. Licens	e number		29d. D	29d. Date signed (Month, Day, Year)			
	4		June	en Co a) leceses &	2			HO	0611	7		ne	13	, 2007	
3	10		30. Name and address		ompleted cause of		n 23a) (Type,	, Print)	251	E. An	TIETZ	N Di	55			
70	Sta	ite	31. Date filed (Month)		32. B gist	, =-	4	,	1 0	Jus Jest	7. 100	احن	لسكن ٢٠٠١	-		_
	Registi		.,,	-11 10 /	.007	ne.	B 4	boul								

		1	For State Registrar		State	of Mary	land / Del	oartmen e <i>rtificat</i>					giene	007	2109;
	Discount of the		1. Decedent's Name	(First, Middle,	Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medica	al I	Charles H									6		2007	6:45 P M
	Examine		4a. Facility Name (If							Location of	of Death			ounty of Death	
			Atlantic (la at birth de		rlin		24 Hrs	R Data of Rid		rceste	r place (State or Foreign
	Funeral		5. Social Security Nu		6.Sex 1.2XM 2F		n yrs. last birthda '4 Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da 8 / 17 / 19	y, Year)	Cou	ntry) NY
	Director		078-26-37. Usual Residence of				4		L	li		0/1//13	132		
	/land		10a. State	10b. County		10	c. City, Town or	Location							10d. Inside City Limits
	Man,	اِق	MD	Worce	ster		0cean	Pines							1 ☐ Yes 2 No
	r 286	\mathbf{x}	10e. Street and Num	nber				10f. Zig	Code				10g. Citizer	n of What Cou	ntry?
	1 wit		17 Sassaf:	ras Lar	ie			2	1811				US	A	
	dea	Funeral	11. Marital Status		12. Was De	ecedent Eve Forces?	r in U.S. 1	3. Was Dece	dent of Hi	ispanic Ori in, Mexicar	igin? (Spendon, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	
98	or it		1 Never Marrie	_	ed 1 ☐ Yes,	s 2.∏xNo Give ′Dates: Ko	1	1 ☐ Yes						pecify: Lih	ite
5-0036	72 hours after death with the Maryland naturel, or items 23s or 28s-f ehow digal Examinat found be notified at	b o	3 Widowed			Dates: Ko	100 D-	cedent's Usu	al Ossus	ation			16b Kind	of Business/Ir	
5-	n 72	Completed			grade complete		(Gi	ve kind of wo n. DO NOT u	ork done d ise retired	allon during mos d)	st of work	ing	TOD. IXIII	01 203111933/11	idusiiy
2121	withi ene.	m d	Elementary/Secor	ndary (0-12)	College	(1-4or 5+)		rviso					F	looring	1
η Ω	filed Hygi other	ပိ	17. Father's Name (First, Middle, L	.ast)		Jupe	.1 1 1 3 0	01			e (First, Middle			,
イベ <i>シか</i> Marvland	lid be lental rked c	ന	George Gel	her						Lill	lian	Schalle	nberg	<u> </u>	
a < ≤	shou and N ma	7	19a. Informant's Na	me/Relationsh	ip (Type, Print)		19b. Ma	iling Addres	s (Street	and Numbe	er or Rur	al Route Numb	er, City or T	own, State, Zi	o Code)
	er tra]	Maureen G	eher /	Wife					Lane		ean Pir			
ore-	of He of He r oth		20a. Method of Disp		3 □Removal fro	m State	,	rematory`or	other plac			Date		tion - City or T	
<u> </u>	Pag ment ant: i		4 Donation			- Ciaio	Gardens					/2007		n Pine	
© 114 1011 ■ Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marical Examiner mast ke notified at once.		21. Signature of Full	neral Service L	Mach	100		22. Name a				he Burl Berlin,	_		Home
න			23a. Part . Enter the shock, or hear	ne disease, or nt failure. List	complications that	at caused the n each line.	e death. Do not	enter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final n	a Ai	nvata	rophi'c	- (a)	Lero	1)	sclo	TOSI	7		011307 0110 25000
	/Medical Examiner		resulting in death)		Due	to (or as a c	onsequence of):								
1		_	Sequentially list cor	nditions,	b	to for as a c	unsequence of).								
1911년 760.	nsit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	rlying injury		(
	ate be executed hysiclen and the burial-transit	Exa	resulting in death) L	ast	c. Due	to (or as a c	onsequence of):								
1791 8760.	tte be e nysicler ne buri	Cai			d										
× 0	tifical ng ph as th				-										
Box	death certifica e attending ph d for use as th	ar/k	IF FEMALE: 23b. Was decedent			outcome of p		3 □Ectopic g	oregnancy	,			23	d. Date of delin	very Day Year
\circ	e dea the att	Physician/Med	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∏Pre 9□ Un	egnant at tim known	e of death	5 Other (s	pecity)					Workin	54,
Q 0.9	that the ed by the detact		Part II. Dther signifi	icant conditio	ne contributing to	o death but r	not resulting in th	e underlying	cause on	en in Part I		23e. Did	obacco use	contribute to	the cause of death?
- 6 8	se us	ğ	Fait II. Duler signil	icant condition	113 CONTRIBUTING (C	3 434 (1)	Tot 1000iting in the	o arraony ing	ouuso giv	OII WIT GIT			Yes 2□		
S 75 Beord	v req beer shou	ete										24a, Was	an	24b. Were aut	opsy findings available
	iysicien: The lav iis certilicate has director, page 2	Completed										auto	psy ormed2	prior to c death?	ompletion of cause of
300	n: Ti flicate or, pa	ပိ	25. Was case refer	red to medical		<u> </u>				26 Plac	e of Deat	1 ☐ Yes	2 No	1 Li Yes	2 No
Ž, 6≥	Physicien: this certific	To Be	examiner?	,	Hospital:	npatient	2 ☐ ER/Outpa	tient 3 D	OA Oth	oc		ome 5 ☐ Res		Other (Spec	ifv)
200	g Phys er this eral di		27. Manner of Death	h	28a. Da	ite of Injury fonth, Day Y			28c. Injur Wor			28d. Describe			,
5 7 5	Attending r death. ector: After	atio	Natural Accident	5 🗌 Pendin investig	9	ionin, Day 1	ear) Injui	м		Yes 2□]No				
Server, 07 Division	il or Atte after de Directo	Certification;	3 Suicide 4 Homicide	6 □ Could r determ	nod 200. Fi	ace of Injury ilding, etc. (- At home, farm, Specify)	street, facto	ry, office				(Street and wn, State)	Number or Ru	ral Route Number,
		Medical C	29a. Certifier (Check only one)		g Physician: To Examiner: On the and m	the best of re basis of ex anner states	my knowledge, di ramination and/o	eath occurred r investigatio	d at the tir n, in my d	ne, date a pinion, dea	nd place, ath occur	and due to the red at the time.	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	Fo the within To the complex	Me	29b. Signature and	title of certifier				29	c. Licens	e number			29d. Date	signed (Month	, Day, Year)
			> PATA		M.D				Do	06	4/2	e	06	5/15/	107
	BASHI		30. Name and addr	ess of person	who completed c	ause of dear	th (Item 23a) (Ty	oe, Print)	Way	ורלי	ve	Berli'	n M	D 21	811
	Star Registra		31. Date filed (Mon	th, Day, Year)	2007	2. Registrar's	Signature	book	,						
		4.		JUN I		THE REAL PROPERTY.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Steven Craig Harris 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day June 18, 2007 Year 1320 hrs Medical Examiner Steven Craiq Harris c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 327 Reserve Gate Terrace If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Country) 1 X M 2 49 1958 215-72-6149 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Yes 2XX No 28a-f show Silver Spring MD Montgomery Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 23a or 327 Reserve Gate Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? Never Married 2 X Married 2XX No Yes 5 Specify White If Yes, Give Year Yes 2 X No specify: 3 Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 12 Construction Self-employed nit. Pages 1 and 2 should be filed within partment of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be Jean K. Hearne Glendal W. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3902 Silver Map<u>le Court,</u> item 27 Karen A. Harris Rockville, MD 20853 /Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) or other 1XX Burial 2 Cremation 3 Removal from State Important: If Donation 5 Other Specify: Memorial Park 23. 2007 Olney, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter the disease, **Physician** Between Onset and failure. List only one caus on /Medical Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate coupe. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical XUNPENDED AMENDED #23a,27,28a-f, attending physician or use as the burial perME.g869, 7/10/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be extuined thours after death.
To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Νo ✓ Yes 2 Na 1 V Yes 26.Place of Death (Check only one 25. Was case referred to medical Division of Vital Be Other₄ examiner? Residence 6 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Natural Yes 2 XNo Pending ıınk Fnd 6/18/2007 Fnd 12:45 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc XCould not be 3 Suicide Town, State) MD (Specify) Reserve Gates Ter. Silver Spring, Found: residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) June 19, 2007 O.C.M.E.

10

Susan Hogan MD. State Registrar

egistrar's Signaty

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

		•	For	State of M	larylan	•	artmen					giene	007	21096		
			Registrar 1. Decedent's Name (First, Middle, La:	st)			tirroat	0 0. 1	Journ		2. Date of Dea		the set of	3. Time of Death		
	Physicia		Hazel R. Hall	,							Month June	16	2007	6:15P	V	
	/Medic Examin	*	4a. Facility Name (If not institution, give	e street and numbe	r)		4b. City,	Town, or	Location	of Death	June	1	County of Dea		_	
	Examili	er Se	8136 Phirne Rd				G1	en 1	Burn	ie		An	ne Ar	undel		
-	Funeral	•	Social Security Number 6. S		Age (In yrs.	iast birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h v Year)	9. Bir	thplace (State or Foreign	gn	
	Director	0	212-22-8896	□M 2 X 7F		85 Yrs.	IVIOLITIS	Days	riours	19101.	8. Date of Birt (Month, Dat July	7 1	921	Maryland		
	p ,	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation							10d. Inside City Limit	s	
	ehov ehov	5	Maryland Anne A	rundel		len B	_	e						1 ☐ Yes 2XN		
	death with the Maryland ma 23a or 28a-f show	Director	10e. Street and Number				10f. Zip					10a Citi	zen of What C	puntry?		
	with Be or	급		Foot				106	1				SA	,		
	eath	Funeral	8136 Phirne Rd	12. Was Deceder	nt Ever in U	.S. 13.				igin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Am			
_	r Iten	들	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give	s?						Rican, etc.)		Black, Whi			
3	hours after death with the Marylan tural', or Itema 23e or 28e-f ehow al Exerciper most be nellified at	ρ	3 ∰Widowed 4 □ Divorced	If Yes, Give *Year or Dates	š:		1 🗆 Yes	ΣΣ Nο	Specify:				Specify: B	lack		
5-0036	72 ho	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usu kind of wo	al Occupa	ation	st of work	ina	16b. Kii	nd of Business	/Industry		
N	within 72 ene. than "nat	ngu	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT u	se retired)							
7	filed w Hygier other th	ဝိ	5th 17. Father's Name (First, Middle, Last,	0		Но	usew	ife	10 Moth	ne'c Name	e (First, Middle,		ne			
S E	D d la	Be		,								maradir	oomano,			
Maryland	hould d Men marke matic	٩	Herbert Brown 19a. Informant's Name/Relationship (Type Print)		19b. Maili	na Addres	s (Street a		a Jo	I Route Numbe	er, City o	Town, State,	Zip Code)		
<u>8</u>	id 2 s lith an 27 is trau		Hazel R. Morga		er)	8136	-							, Md.2106	1	
<u>6</u>	t Healt them 2 ther		20a. Method of Disposition		20b. F	Place of Dispo	osition (Na	me of			Date		cation - City o			
Ę	8 2 = 5		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		(e)	dar H		sirior piac		6-20	0-07	G1e	n Bur	nie, Md.		
Baltimore,	mit. Pa pertmen sortant: rinjury is.		21. Signature of Funeral Service Lice								Morti					
ñ	F 5 F 6		Javy D. B	sese Mo	648	3 8	21 W	est	St.	Ann	apolis	5, M	id. 21	401		
11,7			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each	line				-			rrest,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	ischi	EM1	CC	ARD.	OM	YOR	DAT	44			Onset and Death	JIM	
- 4	/Medical		resulting in death)	Due to (or a	as a conseq	quence of):			,					1100015/001	10	
Б	Examiner	_	Sequentially list conditions,	b. CORO	NAR	Y AL	थास	ry	D (S	514	SE			MANY YEAR	9	
	be tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a conseq	luence of):										
	be executed icien and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):										
90	be egicien buria	cal E				,										
687	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit			d												
	nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			75						23d. Date of de	elivery		
ň	death e ette	Icla	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 Live birth 4 Pregnant	at time of d		□Ectopic p □ Other (s						Month	Day Year		
P.O. Box	by the	hys	9 Unknown	9□ Unknown	·											
	gned be de	Completed by Physician/Med	Part II. Other significant conditions	-		-			en in Part	I.			co use contribute to the cause of death?			
ord	pluoi bluoi	ted		ARSE W			iner	7 1			10	Yes 2	2 No 3 Probably 4 Unknown			
Ö	25 8	nple	UNINARY TRACT	INFE	TION	03					24a. Was autoj	psy	prior to	utopsy findings availat completion of cause o	ole of	
E	The cate h	Co									1 Yes	ormed? 2 No	death? 1 ☐ Ye			
Vital Records,	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oa Oth			h (Check only o					
ō	Phys rat dii	: To	1 ☐ Yes 2 🕅 No 27. Manner of Death	1 _ Inpa		ER/Outpatie		OA 28c. înjur	4 🗆 14	ursing Ho	me 5 Resi 28d. Describe			ecify)		
o	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, L	Day Year)	Injury	м	Wor	k? Yes 2□]No			,			
Division of	Atten r deal sctor	flca	3 ☐ Suicide 6 ☐ Could not b	28e. Place of	Injury - At h	ome, farm, st	reet, factor	y, office						Rural Route Number,		
á	s afte	Certification:	4 ☐ Homicide determined	building,	etc. (Speci.	fy)					City or To	wn, State	,			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the second page.		29a. Certifier 1 Certifying P	hysician: To the be miner: On the basis	st of my kno	owledge, dea	th occurred	at the tir	ne, date a	nd place,	and due to the	cause(s)	and manner	as stated.		
	the H iin 24 the F iplete	Medical	one)	and manner	stated.	ation undo in				4(11 00001	roa at trio timo,					
v	さまる。 - 2000 ~	~	29b. Signature and title of certifier	1.17			28		e number					nth, Day, Year)		
	12_D	7	1 cup of	U MS	*		D		580				18/0			
	1/10		30. Name and address of person who	completed cause of	death (Iter	m 23a) (Туре Съ Д	, Print)	4114	#/A	Ca	EN RIV	RN.	E M	7.1061		
	Sta	te	30. Name and address of person who CANLOS D. 2/CC 31. Date filed (Month, Day, Year) JUN 1.9 2	32. F gi	strar's Sign	ature	<i>P</i>		, ,	<u>_</u>	101-100	V 1 0	- 00	2 0 0 0 0 1		
6 T	Regist		JUN 1 9 2	2001	ene	1. 1	Speak									

			1 - For State Registrar	State of Marylar		artment rtificate			nd Me		giene Reg. No.	017	210	97
Т	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of Dea _ Month	Dav	Year	3. Time o	
	/Medic	al		Margie Ellen	Jones	o. T		1 1		June	22	2007	0710	A M
S. A.	Examin	er	4a. Facility Name (If not institution, give Laurelwood Care			Elkt		Location of	Death		4c. (County of Death Cecil		
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1	Year	If Under 2		B. Date of Birt	h	9. Birth	place (State	or Foreign
3	Director		226-28-7072	□M 20XF 86	Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year) 192(_{intry)} ginia	
	p >		Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Lo	ocation							10d, Inside C	ity Limits
	Aaryla Ped at	or			•	ocation								2 [v] No
	289-	Directo	Maryland Cecil 10e. Street and Number		E1kton	10f. Zip C	Code				10g. Citiz	en of What Cou	intry?	
	h with		248 Union Church	Road		21	921				Un	ited St	ates	
	ome 2	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decede	nt of His	spanic Orig	in? (Spec	ify Yes or No ican, etc.)		4. Race - Amer Black, White	ican Indian,	
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ሺ No If Yes, Give		1 ☐ Yes 2		Specify:		,		Specify:		
Ö	filed within 72 hours after death with the Maryland Hygien. Ither than "natural", or iteme 23a or 28a-f ehow wit, the Medical Exeminer must be notified at	ed by	3 ₩ Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual	Occupa	ition			16h Kin	W.	hite	
7	in 72 n "na"	Completed	(Specify only highest grad	de completed)	(Give	kind of work DO NOT use	done d	uring most	of working	9		ctrical	•	
212	d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	As	semble	er					ufactur		
D .	al Hyg	Bec	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Middle,	Maiden :	Sumame)	_	
yla	should be and Mental marked o umatic eve	To	Dover Stinson							Barrett				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. In a marked other than "natural; or tieme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (7								-	Town, State, Z		
ė,	1 and Healt am 2		Linda S. Cox/Dat	20b	Place of Dispo	sition (Name	of	1				yland 2 cation - City or 1		
altimore,	Pages nent of int: If It		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Gi	Ipin Ma	matory or oth	er place		June 2007			on, Mar		
	nit. P artme ortan Injur		21. Signature of Funeral Service Licen:	IIIC	morial		Addres			als, P		on, nai	yrand	
ä	Depa Impo any i		Done de la	Decker	10	icks Ho	ome Stoc	for F kton	Uner	als, P et. El	.A. kton	, Maryla	and 219	921
) e.	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	th. Do not en	ter the mode	of dying	g, such as c	cardiac or	respiratory ar	rest,		Approxima Interval Be Onset and	tween
- 18	/Medical Examiner		1	Due to (or as a consec	quence of):	100								
N.,		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a consec	uanca of):	440								
)	outed id ansit	Examiner	Cause (Disease or injury that initiated events	Cer	elle	VOS	nl	en	in 4	How	4			
760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of);					42				
876	icate b physic s the bi	dicai		d					_		T.	_		
.O. Box 6	death certif e attending id for use a	Physician/Med	in the past 12 pronths?	23c. If yes, outcome of pregnancy 1							2	23d. Date of delivery Month Day Year		Year
<u>Р</u> .	hat the de d by the a letached	Phy	9 ☐ Unknown Part II. Other significant conditions or		culting in the u	ndorhing car	ISO GIVO	un in Part I		23e Did t	obacco u	se contribute to	the cause of	death?
ords,	law requires that the as been signed by th 2 should be detache	ted by	ratu. Ottor significant conditions of	minutaling to death but not re-	salting in the u			HIHIPANI.		101		J. 1	bably 4	
œ	The ate h page	Completed					autopsy prio performed? dea					prior to c death?		
Zita	Icien: Sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o				
o	Phys this ral dir	٠ <u>۲</u>	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho 28a. Date of Injury 28b. Time of 28c. Injury at						e 5 Resid			ufy)	
u O	ding h. After funer	tion	1 Naturat 5 ☐ Pending	(Month, Day Year)	Injury	M	c. Injury Work			d. Describe i	10W IIIJuly	occurred		
Divisi	To the Hospital or Attending Physicien: within 24 hours steer death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined							Bf. Location (S City or Tox		d Number or Ru	ral Route Nur	nber,
	Hospital 24 hours a Funerel letely filled	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	/sician: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the tim	e, date and inion, death	place, ar	nd due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					number	-		29d. Date	signed (Month	, Dey, Year)	
)			In cer 10	is			Do	182	. 3.		June	22, 200	07	
	1		30. Name and address of person who o				11							
	1		Jui-Chih Hsu, M.D.	, 223 West Ma:	in Stre	eet, E.	Lkto	on, Ma	ryla	nd 219	21			
8	Sta Registr		31. Date filed-(Month Day. 3 ear)	32. Registrar's Sign	Spare	and a								

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 5 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , Day 2007 Year June 12, **Physician** 2:00 P.M Brenda Lee Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Lusby 13395 Olivet Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/16/1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Maryland 65 216-40-5948 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County MD Calvert Lusby 1 ☐ Yes 2X No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20657 United States 13444 Olivet Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology 12 Hairdresser / Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Marie Thomas Earl Stewart Mc Cready 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13444 Olivet Road, Lusby, Maryland 20657 John F. Johnson, II (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Metropolitan Crematory 6/13/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SMALL CELL LUNG CANCER WITH METS U mon bs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 res 2 No 3 Probably 4 Unknown ASTHMA, CAD CKD Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Sans Hame 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11910 H. G. Trueman Road, Lusby, Maryland 20657 Scaria Mathew, MD 31. Date filed (Month, Day, Year)

State Registrar 29a, Certifier

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36969

29d. Date signed (Month, Day, Year)

June 13, 2007

			State of Maryland / Dep		1ental Hygie	ne
		_1	- negistidi	rtificate of Death		. No.
т	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death 1449 M
43	/Medic	al .	Janet L. Johnson	4b. City, Town, or Location of Death	June 1	. 3 2007 1449 M
Ú	Examin	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	Annapolis		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		216-68-9564 1 M 2 N F 51 Yrs.	Months Days Hours Min.	Feb 28	1956 Maryland
	P .	-	Usual Residence of Decedent 10a State 10b County 10c. City, Town or L	contian		10d. Inside City Limits
	arylar show d at	. 1	Tou. Glato			1√∑Yes 2 □ No
	he M 28a-f otifle	ပ္	Maryland Anne Arundel Annap 10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
	a or			21403	1.59	USA
	ns 23	Funeral	1011 Kensington Way 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 20a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	by Fun	Armed Forces? 1 ▼Never Married 2 Married 1 ↑ Yes 2 ▼No If Yes, Give 3 ↑ Widowed 4 ↑ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
Maryland 21215-0036	hour tural	q pa	15 Decedent's Education 16a Dec	edent's Usual Occupation	16	8b. Kind of Business/Industry
5.	in 72 n "na Nedic	plet	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	aing A	Anne Arundel Co.
212	d with giene ir tha the i	Completed	12th 0 S	ecretary	F	Recreation & Parks
pu	al Hyle I othe vent,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Surname)
<u>yla</u>	Ment Ment arked	2	James Johnson		Hopkins	
/ar	2 short and rismo		1,000	ling Address (Street and Number or Ru		
e,	1 and Health em 27	1 9		1 Kensington Wa		Oc. Location - City or Town, State
JO	ages nt of rt if it		1 ABurial 2 Cremation 3 Hemoval from State	intatory or other place) al Gardens 6-1	9-07	Annapolis, Md.
Baltimore,	artme artme ortani injun	1		Miname Reasser Scill On		6.
Ba	perm Dep Imp any	6. 1		821 West St. An	napolis,	Md. 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on such line.	nter the mode of dying, such as cardiac	or respiratory arres	IIILEIVAI DELWEETI
	Physician	2 1	Immediate Cause (Final disease or condition a.	210		Onset and Death
J	/Medical		resulting in death) Due to (or as a consequence of):			
b	Examiner		Sequentially list conditions, b.			
	ped sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of light)			//
m	xecui and al-trar	xan	that initiated events resulting in death) Last C			
8760,	cate be executed oblysician and the burial-transit					
9	tificate ig physi as the	edi				
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
-	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Medical	in the past 18 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 18 months? 4 □ Pregnant at time of death 9 □ Unknown	Other (specify)		Month Buy Four
P.O.	w requires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ds,	uires signe Id be	d by	Scleroderman		1 ☐ Yes	3 □ Probably 4 □ Unknown
CO	w req	lete	Tata Litit I was Di	9225	24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed	The state of the s		autopsy performe 1∐ Yes 2[prior to completion of cause of death? 1 □ Yes 2 □ No
ita	(0)	a	25. Was case referred to medical	26. Place of Dea	th Check onl one	
or Vital Records,	di S	To B	examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpat		ome 5 Residen	nce 6 Other (Specify)
	ing Pl		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Injury) 28b. Time (Injury) 28b. Time	Work?	28d. Describe how	injury occurred
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,	M 1 ☐ Yes 2 ☐ No	28f Location (Stre	eet and Number or Rural Route Number,
Division	al or A	Certification:	4 Homicide determined building, etc. (Specify)	siredi, idelety, embe	City or Town,	State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de a control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cau urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	000		MA THE MO	D5518	7	6/13/7
	SON SON		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	1	101
	1×		31. Date filed (Month, Day, Year) 32. Regional Signature	re Hrundel P	ledica	1 lenter
	Sta Regist	ate rar	JUN 1.9 2007	L.V.		

DHMH 17 Rev 1/2001

ORIGINAL

07-04780 Karen E James Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Karen	E. James		State of Maryland / Department of the State of Maryland / Department of the State of Learning of the State of Learning of the State of Maryland / Department of the State of The State of Maryland / Department of the State of The S			201	37 2110
	Physic		Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No 2. Date of Death		3. Time of Death
Medic	cal Exam		Karen Elaine James		June 23, 2007	<u> </u>	1246 hrs
\$20			4a. Facility Name (it not institution, give street and its insert	. City, Town, or Location of Death		4c. County of Death Talbot	
			Laston Memorial Hospital	Easton If Under 1 Year If Under 24Hrs.		M/DD/YYYY) 9. Birt	hplace (State or
	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.		Foreign	n
	Directo		212-86-0159 1 M 2XF 43 Yrs.		3/2/196	54	^{untry)} 0klahoma
	ny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
	d how a	_	MD Talbot Easton				1 Yes 2XX No
3	ie Maryland or 28a-f show any fied at once	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Cour	ntry?
3	th the Maryland 23a or 28a-f shomatified at once	ğ	9157 Honeysuckle Drive	21601		USA	
	× 5 5	Funeral	if Va	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
	r death or iten	급	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Yes 2 X No specify:		Specify: Wh	ite
	rs afte ural",	<u>ā</u>	or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's	s Usual Occupation (Give kind of w	ork done 16t	o. Kind of Business/I	
	2 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retin	ed)		
5	5-0036 ed within 72 ho tygiene. other than "na	Completed	12 Lette	r Carrier		Postal Se	rvice
i i	5-0036 Hed within 7 Hygiene. d other than	S	17. Father's Name (First, Middle, Last)		(First, Middle, Maidene Coffman		
- 2	121 d be fi fental arked	o Be	Patrick Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or R			e, Zıp Code)
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Iniportant: If item 27 is marked other than "naturall", in the Medical Estamina.	۲		rald Harbor Rd.	Crownsvi	11e, MD 2	1032
	s, M and 2 fealth item 2		20a. Method of Disposition 20b. Place of Disposit	tion (Name of cemetery,	Date 20	c. Location - City or	Town, State
,	Baltimore, permit. Pages l ar Department of Her Important: If ite		Burial 2 AACremation 3 Removal from State	1 - 1 -	26/2007	Baltimore	, MD
di :	nit. Pa artmel	5	21. Signature of Funeral Service Licensee 22. No.	ame and Address of FacilityHard	lesty Fun	eral Home	, P.A.
0	De de la la la la la la la la la la la la la		1 (5 al + W// 12	Ridgely Ave. Annapo	11s, MD 214	UI	Approximate Interval
	Physicia		23a. Part I. Enter the disease, or complications that caused the death. Do not enter th failure. List only one cause on each line.	e mode of dying, such as cardiac o	r respiratory arrest,	SHOCK, OF HEAR	Between Onset and Death
1	/Medica amine	_	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Double
			h				
2.4		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
7		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
200	auted nd .						
amadria	50, te be executed nysician and	or use as the burial - tra	X UNPENDED X AMENDED #22, perFH, 23a,27,28a-f	, perME, G869, 7/13/	/07 TT		
3	760 icate t	the br	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregna		23d. Date of delive Month	Day Year
7.	certif	use as	past 12 months? 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ott	her (Specify)			
1	Boy death	Physi	1 Yes 2 No 9 V Unknown 9 Unknown		220 Did toba	cco use contribute t	o the cause of death?
.H.	O.O. Box 6876 that the death certificat and by the attending ph	detach hv P		nderlying cause given in Paπ I.			obably 4 V Unknown
1)	cords, P.O. law requires that that been signed by				24a. Was an		autopsy findings available
railed	ord aw req as bee	, page 2 should be			autopsy performe	ed? death?	
B	tal Recol	page			1 Yes 2	No 1 🗸	Yes 2 No
7	cian:	director,		26.Place of Death (Check		esidence 6 Oth	er:
301	of Vi ing Physi After this	_ ভূ	1 Ves 2 No Imparent 2 Environment 28a, Date of Injury 28b. Time of		28d. Describe hov		
47.	nding th.	e funeral	1 Natural 5 Pending Fnd 6/23/2007 Fnd 11:	56 am 1 Yes 2 X No	unk		
1	isic Atter	by the	2 Accident Investigation 3 Suicide 6 X Could not be	et, factory, office building, etc.			Rural Route Number, City
33	Divisior Hospital or Attend 24 hours after death. Funeral Director:	filled in by the fune	3 Suicide 6 X Could not be determined (Specify) residence			^{te)} suckele Dr.	
F	Hosp 24 ho Fune			rred at the time, date and place, an	d due to the cause(s	s) and manner as st id place, and due to	ated. the cause(s)
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated,	29c. License number		29d. Date signed (A	
		2	29b. Signature and title of certifier	O.C.M.E.		June 24, 2007	
			30. Na le and address of person who completed cause of death (Item 23a)				
				Penn Street, Baltimore, MD	21201		
		Stat	e 31. Date filed (Month, Day, Year) 32. Redistrar's Signature				
	Red	aistra	JUN 2 6 2007 June 18 1	and)			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM/1 per PHYS G868 6/29/07 WS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Diane 2. Date of Death 3. Time of Death Elizabeth Kriemelmeyer Month **Physician** 23:33 PIEMELMEYE 2007 ELIZABETH JUN E 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Fecility Name (If not institution, give street and number) HOSPITAL BALTIMORE CITY BALTIMORE CITY HOPKINS JOHNS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12-06-1958 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X**□ F WASH, DC 48 Yrs. Director 213-54-6499 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f ehow the Madical Examinar must be notified at 10b. County 1 Yes 2 No MD. PRINCE GEORGES UPPER MARLBORO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14100 FARNSWORTH DRIVE 20772 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 le marked other then "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NUCLEAR WASTE CONSULTANT SELF EMPLOY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY KRIEMELMEYER, JR. MILDRED FINLEY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY KRIEMELMEYER-FATHER 16900 MATTAWOMAN LN.WALDORF, MD. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State ST permit, Pages 1 Depertment of H Important: If its eny Injury or ot once. ARUNDEL CREMATORY 6-19-07 ODENTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 27. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Fugeral Service Licensee MQ0479 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial Box 68760, Physician/Medical the IF FEMALE: 9SN 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA After thi funeral (ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by determined 4 Thomicide To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KIA AFSHAR MEDICAL DOCTOR

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 06, 16,2007 RES-000

DHMH 17 Rev 1/2001

0

Registrar

State

AFSHAR

31. Date filed (Month, Day, Year)

THE

JUN 2 9 2007

K14

JOHNS

HOPKINS

HOSPITAL, 600 NORTH

WOLFE STREET, BALTIMURE, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 1130PM **Physician** Jeannette Laverne Kirby June 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Port Republic 770 Chippingwood Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Days Hours 1 □ M 2 🔀 F 97 578-86-0288 Yrs. 26 1910 Maryland Feb Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Exeminer must be notified at Port Republic 1 ☐ Yes 2 XNo Maryland Calvert Director 10g. Citizen of What Country? 10e. Street and Number United States 20676 770 Chippingwood Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must gonee. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 XNo Specify: ð 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Rosella McAtee John D. Farrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 770 Chippingwood Dr. Port Republic MD 19a. Informant's Name/Relationship (Type. Print) Rosemary Hill- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 15 2007 St. John Vianney Catholic 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Prince Frederick Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic mD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician theroschero coronamano disease or condition resulting in death) 4eas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes No 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760. To the Hospital within 24 hours at To the Funeral D

with the Maryland

Baltimore, Maryland 21215-0036

tectifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

determined

4 ☐ Homicide

29a. Certifier

Charapeale Beach MO 20732 Robert J Schlagen

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #19b per FH 06-15-2007 Contificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6 9:10AM 12 2007 Leatherman -dn0 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick
nder 1 Year | If Under 24 Hrs. -Rederick Center tenesis oll evelien 8. Date of Birth (Month, Day Year) 1925 9. Birthplace (State or Foreign Country) 5. Social Security Number 214-28-0207 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1□M 2 F 82 ΜD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rei', or Itema 23a or 28a-f show Examinar must be notified at 1 Yes 2 No MD Frederick Middletown Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7822 Myersville Rd. 21769 USA death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married or i Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 □ Divorced "naturel" Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) assembly worker 6 shoe co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvey M. Delauter Fannie M. Shipley 2 3906 Cherry Ln., Middletown, MD 21769 19a. Informant's Name/Relationship (Type, Print) 1 Surial a Cremation 3 Removal from State
14 Domation 5 Other (Specify)
21 Signature of Runeral Septice Lipensee if Item 27 is no or other traun Wayne Leatherman (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Page: Department o Important: If I any injury or 2005e. Lutheran cemetery 6/15/07 Middletown, MD Bonard Homeson Funeral Home P. O. Box 18, Middletown, MD 21769 ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or year failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** artery OPONBRY /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of) ular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit The law requires that the death certificate be executed ementic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 2 No for 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? been signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by 2. No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed/ page 2 No 1 Tyes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 No 2 3□ DOA 1 Inpatient 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0060417 6/12/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah, 65-C Thomas Johnson Dr., Frederick, MD 21702 State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Louis Wesley Miller June 19 2007 7:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Hospice Dove House Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 218-12-7919 84 Director 7, 1923 Mar. Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2833 Carlisle Dr. 21776 filed within 72 hours after death v Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1943-46 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 2 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 manufacturing supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be ဥ Samuel F. Miller Augusta A. Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Florence M. Miller/ wife 2833 Carlisle Dr. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State Important: if it any injury or o 5 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney ValleyGardens 6/23/2007 Timonium, MD 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that eaus shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Cordiomero patre Physician disease or condition 14eax resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an has perform certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 ☐ No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: To the Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated.

DHMH 17 Rev 1/2001

CHACKO 31. Date filed (Mont State

29b. Signature and title of certifier

32 Registrar's Signature

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date_signed (Month, Day, Year)

Registrar

Avenue

29c. License number

0 52035

		For State	State o	f Maryland / De	partment of lertificate of			0.0	107	0.1	107
		Registrar 1. Decedent's Name (First, Middle	e, Last)		ortimouto or	Beatin	2. Date of Death		Yaar	3. Time of I	Death
Physicia /Medic		Alfred Joseph					June	23,	Year 2007	7:47	P ^M
Examin	er	4a. Facility Name (If not institution		ŕ		or Location of Dea		4c. County			
Funeral		Harford Memori 5. Social Security Number	6. Sex	21. 7. Age (In yrs. last birthd	ay) If Under 1 Year		8. Date of Birth	-	ford 9. Birthpl	ace (State or	Foreign
Director		222-05-0088	1 ⊠ M 2□F	85 Yrs	Months Days	Hours Min	July 28,		Nev Nev	v Jers	ey
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	r Location				10	od. Inside Cit	y Limits
Marylan -f show fied at	tor	Maryland Hari	ford	Havro	de Grace_					1 ⊠Yes	2□No
th the or 28a s noti	Director	10e. Street and Number	Ord	Havie	10f. Zip Code		10	g. Citizen of	What Count	try?	
ath wi		516 Camilla St.	I to W B		21078			U.S.A	• ce · America	a ladian	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Ex miner must be notified at	Funeral	11. Marital Status1 □ Never Married 2 Marr	Armed Fo	orces? 2 No		oan, Mexican, Pue	rto Rican, etc.)		ck, White, e		
ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve ates: 43-44	1 ☐ Yes 2 ☑ No	Specify:		Specif	y: W	hite	
"natu	Completed	15. Decedent (Specify only highest	t's Education st grade completed)	16a. De	ecedent's Usual Occu live kind of work done le. DO NOT use retire	pation during most of wo	orking	6b. Kind of B	usiness/Ind	ustry	
withir iene. than the Me	dwo	Elementary/Secondary (0-12)	College (1	1-4or 5+)	susiness C	,		- Automo	ntive		
ould be filed with Mental Hygiene. arked other thar atic event, the M	Be C	17. Father's Name (First, Middle,	Last)		ubilicob c		me (First, Middle, N				
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	ToE	Attilio Marini				Mary A					
s 1 and 2 should f Health and Mer ftem 27 is marke other traumatic		19a. Informant's Name/Relations			ailing Address (Stree					,	
Health tem 27 i		Mary M. Dough 20a. Method of Disposition	erty (Da		O. Box 59 sposition (Name of crematory or other place)			20c. Location			
Pages ent of nt: If I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	n Cemetei	1	26/2007	Havre	de G	race.	MD
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.	1	21. Signature of Funeral Service	~ ~ ~				lman Mitc				
88 E 8 8		23a. Part1. Enter the disease, or shock, or heart failure. List	QUU		123 S. Wa				Grace	, MD	21078
Medical Examiner bhysician and sthe burial-transit	al Examiner	Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyper Due to	(or as a consequence of): tensive athe (or as a consequence of): (or as a consequence of):		c corona	ry vascul	ar dis	ease		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	су	23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of				'ear			
signed		Part II. Other significant condition Chronic Renal			e underlying cause g	iven in Part I.	23e. Dia top			ecauseo⊺do ably 4 ⊡U	
w requ	Completed by	Atrial Fibrillati		y			24a. Was ar		Were autor	autopsy findings available	
The la te has	omp	Coagulopathy s		to commedia			autops perforn 1 Yes 2	v I	prior to con death?	npletion of ca 2 X No	use of
clan: ertifica ctor. p	Be C	25. Was case referred to medical examiner?		Coumacuii			eath (Check only one			77.	
hysic this ce	To	1⊠Yes 2□ No		· · · · · · · · · · · · · · · · · · ·			Home 5 ☐ Reside			/)	
ding h. After funer	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	9 '	of Injury 28b. Tim hth, Day Year) Inju	ry W	uryaτ ork?]Yes 2∏No	28d. Describe ho	w injury occu	rrea		
Atten r death sctor:	ficat	3 Suicide 6 Could i	not be 28e. Place	of injury - At home, farm,	1		28f. Location (St		ber or Rura	l Route Num	ber,
s after al Dire	Serti	4 ☐ Homicide determ	build	ing, etc. (Specify)			City or Town	, State)			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical (Examiner: On the b	e best of my knowledge, d pasis of examination and/o)
o the vithin 2 o the omple	Med	29b. Signature and title of certifie		ner stated.	29c. Licer	nse number	25	9d. Date sign	ed (Month, I	Day, Year)	
F 3 F 8) (Ja	2-47		חחת	53568		June 2			
~		30. Name and add/ess of person	who completed caus	e of death (Item 23a) (Ty			norial Hos		J, 40		
10			hompson,		S. Union				MD 2	1078	
Sta Registr		31. Date filed (Month, Day, Year)	2007	legistrar's Signature	Jack D'						
ricgisti		JUNA	LUUI ALA	Market Je St	A TOP OF THE PARTY						

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State of Maryla		tificate of D	eath	Reg	ene J. No. 9 11 17 7	0110		
Physici /Medio	an .	1. Decedent's Name (First, Middle, Last) Lawrence Layton	MARTIN			2. Date of Death Month JUNE	Day Year /5 2007			
Examin	- 0	4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or L Hagersto	wn		4c. County of Deat	gton		
Funeral Director		216-22-8936 ^{1⊠M 2□F}	79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 23	(ear) 9. Bird Co	thplace (State or Foreign ountry) Tyland		
aryland show dat	_	Total State	City, Town or Loc					10d. Inside City Limits		
with the M 3a or 28a-f st be notifie	I Directo	Maryland Washington Sm 10e. Street and Number 22108 Holiday Drive	TCHSDUT	10f. Zip Code 21783		109	g. Citizen of What Co	buntry?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★★ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Mas Decedent of His f Yes, specify Cuban 1 ☐ Yes 2☑ No	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.		
within 72 hor ene. than "natur he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0	(Give life. E	dent's Usual Occupat kind of work done du DO NOT use retired) anker	ion Iring most of workii	ng 1	6b. Kind of Business. bank	/Industry		
Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M.	aiden Surname)	-		
uld be Aental rked i	To B	James Augustus Mar	ctin				Rayetta			
nd 2 shoualth and N 27 is mai		19a. Informant's Name/Relationship (Type. Print) Gregory L. Taylor - son					City or Town, State, own, Maryl			
Pages 1 ament of Heamant: If item		Zod. Medica of Bioposition	Cedar Lav	wn Memoria Park	June 2	20, H		, Maryland		
permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee		2. Name and Address 15 East Wi			neral Homerstown, M	ne Maryland 21		
Physician / Medical Examiner bunksician and physician and sthe pnial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
ath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf production in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of do	l elivery Day Year		
w requires that the despect to be some signed by the signed by the signed by the signed to be detached to be de	by	Part II. Other significant conditions contributing to death but not	t resulting in the u	ınderiying cause give	n in Part I.		23e. Did tobacco use contribute to the ca			
The ate h page	Completed			autops	24a. Was an autopsy performed performed to the performed performed to the performed to the performed to the performed performed to the performance and performed to the performance and perfor					
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		othe Othe	26. Place of Deat					
Ing Phys After this funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	of 28c. Injury Work	4 LI Nursing Ho		5 Residence 6 Other (Specify) Describe how injury occurred			
or Attenution deatl	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. (S)	At home, farm, st pecify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,		
e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examoner stated.	y knowledge, deal mination and/or in	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License		1	9d. Date signed (Mo			
. > - 0		Drighad 1 Chilar	_ NO	00	11667		6.15	.00		
H-3		30. Name and address of person who dompleted cause of death Michael MCarmack	11110	Medical	Compu	1teje.	stown 1	NO 21748		
S ⁱ Regis	tate trar	31. Date filed (Month, Day, Year) JUN 19 2007 32. Registrar's S	Signature	perse						

-04546 acy Allen Medvid	Please Ty S	pe or Print in Blac l tate of Maryland / D	epartment o	f Health a	re All Copi nd Mental H	es Are Legi lygiene	ble.	
	1- For State Registrar		Certificate of	f Death		Reg.	No.	3. Time of Death
Physician/ edical Examine	Tracy	Allen Medy				Month L June 14, 20		0301 hrs
	4a. Facility Name (if not instituti 15000 blk Sabillasvill			4b. City, Town, Thurmont	or Location of Deat		4c. County of Dea Frederick	
Funeral Director	5. Social Security Number 217–96–1324		n yrs. last birthday) 35 Yrs	If Under 1 Your Months Do		_	(MM/DD/YYYY) 9. B 1972 Fore	irthplace (State or ign country)Maryland
nd how any ce.		anklin 10c	c. City, Town or Loca Waynesh	tion				10d. Inside City Limits 1XX Yes 2 No
the Maryland a or 28a-f sh tiffed at onc		and Avenue		10f. Zip Code	17268	10g	. Citizen of What Co USA	untry?
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	11. Marital Status 1 Never Married 2XX	1 Yes XX	No If	Yes, specify Cub	Hispanic Origin? (9 pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
s after ral", niner	3 Widowed 4 D	livorced If Yes, Give Year or Dates: pecify only highest grade comple	1 1 162 Decede		No specify: pation (Give kind o	f work done	16b. Kind of Busines	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Marhell Hygens in the Maryland int: If item 27 is marked other than "natural", or items 23a or 28a-f she in other fraumatic event, the Medical Examiner must be notified at once To De Commissed by Ermoral Director	Elementary/Secondary (0-12		during r	most of working of Saw Or	ife. DO NOT use re perator	etired)	Construct	ion
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medics		e, Last) dvid				ne (First, Middle, M y (nee Bo		
MD 2121. d 2 should be fil the and Mental 1 n 27 is marked aumatic event,			19b. Mailii 24	ng Address (Si 45 Cleve	eland Ave	., Waynes	per, City or Town, Sta Sboro, PA	17208
Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra	L. =	on 3 Removal from State	Smithsbur	other place) rg Crema	atory 20	ine 21, 107		g, Maryland
Baltimor permit. Pages Department of Important: If	11. Signature of Fundam Service	ce License Paul T. Loc	(-K)					al Home, Inc. A 17268
Physician Medical	failure. List only one caus	Multiple Injuripe	e leath. Do not enter	the mode of dyi	ng, such as cardiae	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disea or condition resulting in death		uence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		uence of):					
cuted and transit	if any, leading to immediate cause. Enter Underlying Caus (Disease or Injury that initiated events resulting in death) Las		uence of):					
e execut vian and rial - trai	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	UNPENDED IF FEMALE: 23b, Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	4 Pregnant at tin	2	Fetal death Other (Specify)	3 Ectopic pre	gnancy	23d. Date of delive Month	very Day Year
P.O. Bcs that the degree by the edge of detached for	<u> </u>	ditions contributing to death b	out not resulting in the	e underlying cau	se given in Part I.			to the cause of death?
ords, P.O. w requires that the s been signed by t should be detache	Completed		-			24a. Was a	sy prior	e autopsy findings available to completion of cause of
of Vital Recoing Physician: The law	OS			26 F	Place of Death (Che	perfor 1 Yes		
Vital Rec	25. Was case referred to med examiner? 1 Ves 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		Othors		Residence 6 🗸 O	ther: Scene
on of \\ nding Phy th. r: After tt te funeral (27 Manner of Death	28a. Date of Injury (Month, Day, Yea POUND:	28b. Time of FOUND: 0243 hrs	· ' ' .	Injury at Work? Yes 2 ✓ No	28d. Describe h Passenger a	now injury occurred auto fixed objec	t collision
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been so completely filled in by the funeral director, page 2 should	3 Suicide 6 C	Jun 14, 2007 28e. Place of Injur (Specify) Loca	ry - At home, farm, st	treet, factory, off	ice building, etc.	or Town, S		Rural Route Number, City nurmont, MD
To the Hospi within 24 hou To the Funct completely fi	_ 29a. Certifier 1 Cortificing	g Physician: To the best of my lexaminer: On the basis of exami	knowledge, death oc ination and/or investi	curred at the tim gation, in my op	e, date and place, inion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due t	stated, o the cause(s)
To To con	29b. Signature and title of cer	and manner stated			cense number		June 14, 2007	•
	20 Name and address of	son who completed cause of dea	ath (Item 23a)					
SH-12	Tasha Greenberg	/		11 Penn Stre	et, Baltimore,	MD 21201		
Sta	te 31. Date filed (Month, Jak Me	200 32. Registrar's	s Signature	1 .				

Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State	state of Marylar		artment of H <i>tificate of L</i>			giene Reg. No.		
	14:		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath 💪	107	3. Time of Death
ě	Physicia	_	Claralee	Milburn				June	12 20	Year 07	9:20 P M
	/Medic	C	4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	ourc		ty of Death	7.201
	Examin	er	Anne Arundel Medical			Annapol	is		Anne	e Aru	nde1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	th		place (State or Foreign
	Director		220-38-1006	² X F 66	Yrs.	Months	Tiours IVIIII.	Dec 21	, 1940		inia
	P.		Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Lo	cation				1	Od. Inside City Limits
	anyla show d at	<u>-</u>	MD Anne Arun		ty, 10tm of 20	Shady S	a5 i				1 ∐ Yes 21⊠ No
	he M 28a-f otifie	Director		ueı		10f. Zip Code	ide		10g. Citizen o	f What Coul	ntry?
	with t	٦	10e. Street and Number				764			SA	,
	eath	eral	1633 Cedar Lane	Was Decedent Ever in U	J.S. 13.			ecify Yes or No		ace - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🏿 No	an, Mexican, Puèrto Specify:	Rićan, etc.)	Spec	ack, White,	etc. ite
21215-0036	72 hour 'natural dical E)	Completed by	15. Decedent's Educat (Specify only highest grade c	ion	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind of	Business/In	dustry
121	vithin ne. han '	E I	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	"		own	home	
2	Hygie Hygie ther		12 17. Father's Name (First, Middle, Last)		1101	Total Control	18. Mother's Nam	e (First, Middle	1		
Maryland	d be ental ced o	o Be	Lester A. Do	onivan			Edith		M	cClan	ahan
Z.	shoul nd M mari	<u>٩</u>	19a. Informant's Name/Relationship (Type	Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numl	er, City or Tow	n, State, Zij	code)
ž	nd 2 alth a 27 is 27 is		George S. Mlburn,	Jr., spouse	1633	Cedar La	ne, Shady	side,	MD 20	764	
altimore,	item		20a. Method of Disposition		Place of Dispo cemetery, cre	osition (Name of matory or other place		Date	20c. Location	n - City or T	own, State
Ē	Page nent d int: If		1 ☐ Burial 2 X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)		tropoli	itan Crem	atory 06-	-13-07	Alexa	ndria	, VA
ati	Departr Importa any inju		21. Signature of Funeral Service Licensee			2. Name and Addre			uneral		
8	9 9 E 2 9	Ш	William K. Gr			325 Mt. H				D 207	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Sep.	si's						days
140	/Medical Examiner		resulting in dealin)	Due to (or as a conse	quence of):						
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events c								
ó	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
8760,	te be ysicia ne bur	dical	d								
Φ	rtifica ng ph as th	Jed	IF FEMALE:	-							
O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	: If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		1	Date of deliv Month	very Day Year
P.0	that the de ned by the detached		Part II. Other significant conditions contr	ibuting to death but not re	sulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
Records,	uires sign	d by	Psoriatric Arth	rifig				1	Yes 2 🗖 No	3 □ Pro	bably 4 Unknown
S	w require been si	Completed						24a. Wa		b. Were aut	opsy findings available
Re	The lav	티	-					aut per 1□ Yes	opsy formed? 2 No	prior to c death? 1 ☐ Yes	ompletion of cause of 2□ No
Vital			25. Was case referred to medical				26. Place of Dea				
>	Physician: r this certificaral director,	o Be	examiner? 1 ☐ Yes 2 No	spital: 1 1 Inpatient 2	 ☐ ER/Outpatie	nt 3□ DOA Oth	ner: 4 \(\sum \) Nursing H	ome 5 Re	sidence 6 🗆	Other (Spec	ify)
101	ding Ph n. After thi funeral	ü	27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time (of 28c. Inju Wo	ry at rk?	28d. Describe	how injury occ	curred	
Ö	Attendir death. ctor: Af	atio	2 ☐ Accident investigation				Yes 2 □ No				
Division	l or Att after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, si cify)	treet, factory, office		28f. Location City or T	(Street and Nu own, State)	ımber or Ru	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my ker: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) and e, date and plac	manner as ce, and due	stated. to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	0./		29c. Licens	se number		29d. Date sig	ned (Month	n, Day, Year)
			Ireld	Isech, MD			46052		01	13/09	
(25		30. Name and address of person who com Since a Buch 31. Date filed (Month, Day, Year)	opleted cause of death (It	em 23a) (Type	Pri Parhway	annap	olis, or	D		
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 4 2007	32. Registrar's Sig	nature South	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day}2007 **Physician** J_{une}^{Month} 24, Shem Carlis Nininger Jr 6:03 am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kline Hospice House Frederick Mount Airy If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12 M 2□F 224-24-0241 Director 81 Virginia Dec 6, 1925 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Maryland Frederick Jefferson 1 ☐ Yes 2 No Director 10f. Zip Code 21755 10e. Street and Number 2633 Lander Road 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite, any Injury or other traumatic event, the Medical Examiner 1 XYes 2 No 1943-If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Mechanic Elementary/Secondary (0-12) College (1-4or 5+) Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shem Carlis Nininger, Sr Mae Caldwell Η ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Shirley Wright Nininger, Wife 2633 Lander Road, Jefferson, Maryland 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem Gardens Jun 27, 2007 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License 22. Name and Address of Facility ord P.A. Funeral Home √M00706 106 East Church St, Frederick, MD 21701 23a. Part). Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Malignant Melanome with home metastacing.) Approximate Interval Between Onset and Death **Physician** Malignant Melanoma with lung metastasis years disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed slcian and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending physical for use as the E 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus, Type II 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Hospice Other: 4 Nursing Home 5 Residence 6 NOther (Specify 1 Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this House 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. 28c. Injury at Work? 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D10587 June 26, 2007

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature flower to figure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Name and address of berson who completed cause of death (Item 23a) (Type, Print)

George I. Smith, Jr, M.D., Med.Dir., Hospice of Frederick Co, 516 Trail Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🗇 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dąy Year **Physician** illiam 200 ar3005 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Valisburu WICOMICO If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □XM 2 □ F Months 220-28-0436 75 Director 10/4/1931 Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits show If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 □Yes 2 □No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12234 Green Ridge Lane 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Delmarva Power Manager and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Howard Parsons Lillian Cropper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a If item 27 Sharon Parsons / Wife 12234 Green Ridge Lane, Ocean City, MD 21842 other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Evergreen Cemetery 6/18/2007 Berlin, MD 22. Name and Address of Facility The Burbage Fuenral Home 21. Signature of Funeral Service Licens 108 WIlliam St., Berlin, MD 21811 min Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BEADDER CARCINOMY **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner CHRONIC UBSTRYCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown ģ sign**e**d k d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Crobably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ Vo cate has t page 2 s autopsy performe 2 XNO certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA မ this 27. Manner of Leath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Hospital or Attending (Month, Day Year) Natural Injury 1 ☐ Yes 2 ☐ No n 24 hours after death. The Funeral Director: A pletely filled in by the death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BA6+1

the

0

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of cortifier

31. Date filed (Month, Day, Year)

and manner stated.

29c. License number 00048510 29d. Date signed (Month, Day, Year)

P.O Box # 1733 SALISBURY IND 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment or rtificate				R	eg. No.	007	21	13
35	Physici /Medic		1. Decedent's Name (First, Middle, Last) WALTER RATKOWSKI							2. Date of Dea Month UNE 14	Day	Year 7	3. Time of 1:30	Death A ^M
	Examin	er	4a. Facility Name (If not institution, give s ROCKVILLE NURSING H	OME		4b. City, To	ROCE	KVILL	ĿΕ				GOMERY	
*	Funeral Director		5. Social Security Number 6. Sex 061-14-5081	7. Age (in yrs. 8		Months [f Under 2		B. Date of Birth (Month, Day UG 14,	1919	9. Birth	olace (State ontry) NY	r Foreign
	Ba-f ehow	Director	10a. State 10b. County MARYLAND MONTGO		ity, Town or L			KVILL	LΕ				10d. Inside Ci 1⊈Yes	1
	with the	Dire	10e. Street and Number 4723 POWDER HOUSE	T\DT VF		10f. Zip C		0853		1	l0g. Citizen	of What Cou	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show spiritury or other treumatic event. I're Medical Eraini actinistic multilist at an once.	by Funeral		12. Was Decedent Ever in L Armed Forces? 1 ▼Yes 2 No WW If Yes, Give Year or Dates:	11	Was Deceder If Yes, specify 1 ☐ Yes 22	nt of Hisp Cuban,		in? (Spec Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White,		
21215-0036	within 72 ho sne. then "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	(Give	dent's Usual (a kind of work DO NOT use ADMIN	done dur retired)	ring most		9		of Business/In		IMENT
	lid be filed lental Hygie rked other tic event, I	ø	17. Father's Name (First, Middle, Last) STEPHAN RATKOWSKI			HDIII	1:	8. Mother	's Name	First, Middle,	Maiden Su		GOVERN	VIIIIVI
, Maryland	alth and N		19a. Informant's Name/Relationship (<i>Ty</i>) OLGA RATKOWSKI, DAU							Route Number			0 Code) 20853	
Baltimore,	Pages 1 annual of He ment of He mury or oth		20a. Method of Disposition 1 Surial 2 □ Cremation 3 SA 4 □ Donation 5 □ Other (Specify)		Place of Disp cemetery, cre JOHN	matory or other	er place)	y 06	Da 5/20/	- 1		ion - City or To E VILLA		Z
Balt	permit. Departr Importa eny inj		21. Signature of Funeral Service License	98	2]	2. Name and EDWARD 1091 RO	Address SAGE OCKV	of Facility EL FU LLLE	NERA PIKE	L DIREC	TION,	INC.	AND 20	
68760,	Physician Application and Physician and Physician and Physician and Physician and Physician are the physician and Physician are the physic	lical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conse	quence of):	ISEASE							Interval Bet Onset and I YEARS	
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 ☐Live birth 2 ☐Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic prec □ Other (spec					230	I. Date of deliv Month	•	Year
s, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death but not re		underlying cau	ise given	in Part I.				contribute to t		
Vital Record	The law requires that the site has been signed by the bage 2 should be detache.	Completed		SEIZURE DIS	ORDER					24a. Was a autop perfor	sv	24b. Were autoprior to codeath?	opsy findings ompletion of c	
/ita	cian: ertifica actor, p	Be	25. Was case referred to medical examiner?	1		-	-		of Death	(Check only or				
οţ	Attending Physician: The I r death. sctor: After this certificate ha by the funeral director, page	ation: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	⊒ ER/Outpatie 28b. Time o Injury		. Injury a Work?	4 (4)	2	e 5 □ Resid 8d. Describe h			fy)	
Division	in the second	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory,	office		2	8f. Location (S City or Tow		lumber or Rur	al Route Num	ber,
	the Hospitel vin 24 hours a the Funeral C	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, dea nation and/or II	th occurred at nvestigation, in	the time n my opir	, date and nion, deati	d place, ar h occurre	nd due to the d d at the time, d	ause(s) an date and pla	d manner as : ace, and due !	stated. to the cause(s	s)
)	To the within To the comple	×	29b. Signature and title of certifier Patricia /	Tomsko 4	lag,	7011	License r 51916					14, 200		
			30. Name and address of person who copy PATRICIA TOMSKO NA				G-10)O. R	ROCKV	ILLE. N	ARYT.	AND 20	0852	
+1/2 -≥1/2	Sta Regist		31. Date filed (Month, Day, Year) JUN 15 20	32. Registrar's Sign				, 1	0	, .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 10, 2007 8:30 p^M Anna Mae Riegel June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner Anne Arundel Atria Manresa Assisted Living Annapolis 8. Date of Birth (Month, Day, Ye Apr. 23, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1920 **Funeral** Days 1 ☐ M 2 🕱 F 121-14-7993 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show Annapolis 1 ☐ Yes 2 ☑ No Anne Arundel MD ns 23a or 28a-f sh must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21409 85 Manresa Road 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>^</u> 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Elementary School Teacher d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice Smith 17. Father's Name (First, Middle, Last) Be Frederick Baumgarten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s (Health a 191 Cornfield Road, Pasadena, MD Sally A. Bunt/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairhaven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 June 15, Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 □Removal from Stat Stoney Ridge, NY 4 Donation 5 D Other (Specif 2007 21. Sanature of Fureral Service Licy see Barrancodom Statis, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. P 1. Ent or the disease, or complication ock, or leart failure. List only one call that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Car se (Final disease or condition resulting in leath) Physician tesophageal /Medical Due to (or as a construence of): Examiner equentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 1 Tyes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an ate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2□No 1 or Attending Physiclan; 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Medical Certification: To Be Assisted Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Stather (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Living 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation s after oe... ral Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dea To the Funeral Director Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Pertifier (Check only

State

Marcalus, mopa JUN 1 4 2007

one)

29b. Signature and title of certifier

3169 Braverton Rd. Edgewater Mo 21037

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For AMEND#9 Per FH. State of Marylan Registrar 6/18/07 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 **Physician** June Donald Ridenbaugh 11, 5:00 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis - Severna Park Severna Park Anne Arundel 8. Date of Birth (Month, Day, Year, July 20, 1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country West Virginia Mary Lamu **Funeral** Months Days Hours Ĩ933 218-30-2456 73 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2 □ No Director Maryland | Anne_Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1972 Fairfax Road 21401 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married ※XX Married TYYes 2 If Yes, Give 2□NoKorean Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Specify Š 3 ☐ Widowed 4 ☐ Divorced Year or Dates: War Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ridenbaugh Sophie Ugich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chyonia L. Ridenbaugh / Wife 1972 Fairfax Road Annapolis, Maryland 21401 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial **2XX**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) 5 ☐ Other (Specify) Ft. Lincoln Crematory 6/19/2007 Brentwood, Maryland 21. Signature of Fundral Service luicensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as the t attending IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 has page 2 certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1 Accident 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A pompletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

29b. Signature and title of certifie

30. Name and address of person w

31. Date filed (Month, Day, JUN 1 4 2007

Ho completed cause of death (Item 239) (Type, Print)

1 Take 2100 10 1 Danah Drive Chike, MD 21619

29c. License number

32006

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mo 1 - State Certificate of Death		ene 0 0 7	21115
			Tiogradus .	2. Date of Death		3. Time of Death
	Physici	an		Month June 12,	Day Year 2007	9:50 am
	/Medic Examin		Gerald Bartley Swift 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	oune 12,	4c. County of Dea	
	CAGIIIII	CI	Holy Cross Rehab. & Nursing Center Burtonsville		Montgo	merv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign ountry)
Н	Director		NE IVI ZUE	Feb. 8.		land
	, nd		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	anyla shov	ž				1 ☐ Yes 🍱 No
	he M 28e-f	Director	Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code	100	g. Citizen of What C	ountry?
	with be or		1733 Metzerott Road 20783	105	USA	ourtry:
	eath	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Road)	cify Yes or No-	14. Race - Ami	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show early injury or other traumatic evant, If a Madical Exacility trainst be notified at 2008.	by Funerai	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F 1	Rican, etc.)	Black, Whi Specify: Wh	te, etc.
Ŏ	2 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin		3b. Kind of Business	/Industry
2	thin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	<i>'</i> 9		
2	od wi	Son	5+ Catholic Priest		Religio	ous
Maryland	d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name		aiden Sumame)	
<u>yla</u>	Men Men arke	2	Bartley Swift Ellen K			
Jar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print) -Religious Supervisor 19b. Mailing Address (Street and Number or Rural	l Route Number, (City or Town, State,	Zip Code)
ď	l and fealth im 27 her ti		Richard McCann, S.T. 1733 Metzerott Road, Ad 20a Method of Disposition 20b. Place of Disposition (Name of Disposit		lary land 2	
0	ges 1 If of F If ita or ot		1 Burial 2 Cremation 3 Removal from State		oc. Location - City of	TOWN, State
<u>=</u>	t. Pa tmen tant:		'4 Donation 5 Other (Specify) Holy Trinity Cemetery 200			11, Alabama
Baltimore,	Depar Impor eny ir		21. Signature of Funeral Service Lizensee 22. Name and Address of Facility Francis J. Collins 500 University Blvd,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician					Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
L	Examiner	_	Sequentially list conditions, b. ———————————————————————————————————			
	Bd sit	ine	cause. Enter Underlying Cause of the Cause (Disease or injury			
_	and and I-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai E				
687	ficate physis the	edic	0.			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
	that the death ed by the atte detached for	icia	in the past 12 months? 1		Month	Day Year
P. O.	of the d by the tached	hys	9 ☐ Unknown			
	res tha igned be det	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
ord	w require been si should l	peq		1 ☐ Yes	2 □ No 3 □ P	robably 4 Nnknown
Vital Records,	has be	Completed		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
œ —	The ate h page	Com		performe		s 2KNo
ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	(Check only one,)	
Ž	Physician: r this certifica ral director, p	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 🗌 Residen	ce 6 Other (Spe	ecity)
n c	ding Phys T. After this funeral di		1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	v injury occurred	
<u>sio</u>	ttandi death. stor: A	cati	2 Accident investigation M ILITES 2 No			
Division of	for Attano after deatl Director:	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Stre City or Town,	et and Number or F State)	fural Houte Number,
	pital		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cau	ra(c) and manner a	e stated
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mon	ith, Day, Year)
)	6		D0054566	6	112/07	-
	Q.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUN YOUR BLID GALLY 31. Date filed (Month, Day, Year) JUN 15 2007 JUN 15 2007	_ ^		
			Sunita Bho gaili 14 702 chery heat zewal	Silver	pring.	4120906
	Sta		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		, , , ,	
	Registi	ar	JUN 15 2007 Brown St. Specific			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year 2150 < Jun 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Mont ban 9' 23 Na If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours 1 M 2 □ F Months Days Min Director 217-42-8370 83 April 8, 1924 Poland Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes XXNo Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11405 Fairoak Drive "natural", or items 23a 20902 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or item any Injury or other traumatic event; the Medical Exminer: once. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Zygmunt Syski <u>Halina Wisniewska</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Syska /Wife 11405 Fairoak Drive, Silver Spring, MD 20902

e of Disposition (Name of Date 200. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem Cemetery June 18, 2007 Brookeville, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Ligenses 500 University Boulevard West, Silver 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrist, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to intrinculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualty (or as a consequence of) Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 No 9□Unknown The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ a 1 ☐ Yes 2 ☐ No 4 Unknown 3 Probably Be Completed 15 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform ransaminity 5 950 esc 19 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Certification: To 1≱Yes 2□ No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 5e// 1 Yes 2 No may 24 2007 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11 405 FG 17 OGK Dr SI(VEX Sprin, mp 20902 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Sig ature a d title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D42181 June 12, 2007 30. Name and address of person wlo completed cause of death (Item 23a) (Type, Print) Enrique Daza, MD 31. Date filed (Month, Day, Year) Caorgetown Rd. Betherda, MD 20814 32 Registrar's Signature 8600 Old JUN 1 5 2007 Registrar

Syski, Ryszard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2.007 **Physician** Stoner Anthes Margaret June 13, 2:19 P M /Medical 4a. Facility Name (If not institution, give street and number)
16505 Virginia Ave., Cottage 251 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Williamsport If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Mogth, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2**X**F Yrs. Pennsylvania 169-16-1369 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturar", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes X□No Williamsport Washington Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 USA 16505 Virginia Avenue, Cottage 251 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2200 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing 17. Father's Name (First, Middle, Last)
Paul Stoner 18. Mother's Name (First, Middle, Maiden Surname) Edith Anthes Landis Be ဂ 19a. Informant's Name/Relationship (Type. Print Margaret Stoner (Self) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16505 Virginia Avenue, Cottage 251 Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Green Hill Cemetery | 6/19/2007 | Waynesboro, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Civensee Paul T. Lochstampfor 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. Mc0349 18 S. Church Street, Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the dearn. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): with liver metastasis 1 week /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerebrovascular disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2DINO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

13H-12

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia Kuther-Sands, MD 14214 Paradise Church Road, Hagerstown Maryland 32. Registrar's Signature allower

Dunithua Kutther-Sando, no

JUN 18 2007

29c. License number

D47451

29d. Date signed (Month, Day, Year)

June 13, 2007

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#8, perFH, 6/18/07, DPS, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Douglas Thadan 2007 /Medical 6 13 13360 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Willial Balhmorn of Manilmal University CENTER 8. Date of Birth 5/30/48 (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Days Hours 1**™** M 2□ F Months 215-52-8712 59 Director Washington, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6202 Ruatan Street 20740 "natural", or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or itel Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Heatht and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Principal Planning Technician State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Malcolm V. Thaden LaVonne Larson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVonne B. Thaden/Mother 6202 Ruatan Street, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 18, MXBurial 2 ☐ Cremation 3 ☐ Removal from State June Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISGUST disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Month 4☐Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy perform 1□ Yes 21 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X**100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 TYes မှ 2 ER/Outpatient 3 DOA 27. Marrher of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pe 29c. License number 29d. Date signed (Month, Day, Year) 6/13/2007 Pauls! and address of person who completed cause of death (Item 23a) (Type, Print) Shal Balhwors, Marylm Sall 6594419 2/20 strunt

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

JUN

Year)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1635 M 2007 Leberca San /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Washington County Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F 74 Yrs. 20 1933 Pennsylvania Director 217-28-5067 Jan. 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10a State 10b. County 1 ☐Yes 2X No Director Maryland | Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 21740 USA must 11204-B Pepperbush Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 ∏ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical College (1-4or 5+) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) the Homemaker <u>Her own home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Matilda Hassler ဥ Benjamin S. Funk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health Robert L. Teach, Sr. - Husband 11204-B Pepperbush Circle, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of IImportant: If ite any injury or ot once, N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 6/18/07 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical -HBART PAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner EDIAL INFARCTION the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal deal 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 DNo 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Medical Certification: To 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 □ Yes 2 □ No after death. I Director: A: d in by the fu 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide filled within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

05H-8

State Registrar

DHMH 17 Rev 1/2001

JUN 18

29b. Signature and title of certifier

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print), MD, WASHINGTON COUNTY HOSPITAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10a-c feer inf e871 9-10-07 tylene State of Maryland regions Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JUNE 15. 2007 RICHARD Μ. VARNER 12:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea. 8-11-1925 Birthplace (State or Foreign Country)
 OHIO 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1₩ 2□F Months Hours Yrs. 81 Director 296-12-6781 Usual Residence of Decedent 10b. County Lee death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
It is marked other then "netural", or tteme 23s or 28s-1 shoy treumatic event, the Madical Examiliner must be notified at Florida Ft. Myers No Yes 2 No Funeral Director OCEAN CITY WORCESTER 10g. Citizen of What Country? 10f. Zip Code 33908-5946 USA Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CLAIMS MANAGER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARL VARNER MILDRED DOTSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trei once. JOSEPHINE K. VARNER-WIFE 429 BAYSHORE DR., APT # 105, OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 3 Other (Specify) MELSONS CREMATORY 6-16-07 FRANKFORD, DELAWARE 21. Signature of Functal 20 22. Name and Address of Facility MELSON FUNERAL SERVICES FRANKFORD, DELAWARE 19945 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Richard M. Vorner 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed Pheumania The law 24b. Were autopsy findings available prior to completion of cause of death? perform 1 Yes 2 8 No 1 ☐ Yes 2 ☐ No : After this certifical funeral director, p or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No the Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by it filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and close and due to the nauric(s) and manner at stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGH 9733 Healthway drive Berlin MD 21811 Atit Zeeshan BAS 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

DOD

296-12-678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Dawn Marie Wise 7:50 AM M 06 /Medical 23 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Center
5. Social Security Number 6. Sex 17. Ane Illn vrs. last 1 Baltimore Rosedale nder 1 Year | If Under 8. Date of Birth (Month, Day, Year) last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Min Director 589-03-0924 38 May 29, 1969 Illinois Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 XYes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 519 Bourbon St. Funeral 21078 U.S.A. "natural", or Items dical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White þ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Child Care Director Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 2 Robert Gene Wells Betty Jean Wells (Timmerman) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Paul Wise (Husband) 519 Bourbon St. Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State St John the Baptist 06/29/2007 Troy, Illinois 4 Donation 5 Dother (Specify) Cemetery 2. Name and Address of Facility Zellman Mitchell Smith Funeral Home 21. Signature of Funeral Service License 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician adstric ca 10 months disease or condition resulting in death) lung mets /Medical Fue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thin entring Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate has t irector, page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 024356 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Dr. William Water

JUN 2 9 2007

31. Date filed (Month, Day, Year)

9

Registrar's Signature

9000 Franklin Square Drive, Baltimore MD, 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		artmen			and M		1	00	7	21123
			Decedent's Name (First, Middle, Last)		rimoan	01 2	Jean		2. Date of Dea			T	3. Time of Death
	Physici /Medic		FRANCIS LERROY WE	ISMAN					Month O Co	Day	2 20		1400 MM
	Examin		4a. Facility Name (If not institution, give street and number)				Location of			-	County of De		
			St. MARY'L HOLPITAL		1		1201				+ - N		
	Funeral Director			yrs. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth Month Day 02/10/	665	9. E	Birthpla Country	ce (State or Foreign y) .and
Н			Usual Residence of Decedent						02/10/	1313	1 10	·	
	arylan show	_		c. City, Town or Lo								100	d. Inside City Limits
	88-1.9	ecto		Huntingto	1								1 ☐ Yes 2 XNo
	with t	Funeral Director	10e. Street and Number 1865 Holland Cliff Road		10f. Zip	639					en of What ced St		
	me 23	era	11 Marital Status 12. Was Decedent Ever	r in U.S. 13.			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Ai		
9	or Ite	Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		lfYes, spec 1 ☐ Yes 2		n, Mexican Specify:	, Puerto I	Rican, etc.)		Black, W		
21215-0036	72 hours after deeth with the Maryland naturel', or lleme 23a or 28e-f show issel Examilar must be notified at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:								Specify:	Whi	.te
15-	n 72 i	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usua kind of wor DO NOT us	rk done d	urina mosi	t of workii	ng	16b. Kin	d of Busine	ss/Indu	stry
212	e filed within al Hygiene. other then "	omp	Elementary/Secondary (0·12) College (1-4or 5+)		onel	,		nt		Depa	artmen	nt c	of Army
ğ	be filed within 72 hours after deeth with the Marylan stal Hygiene. ed other than "naturel", or Iteme 23a or 28e-1 show event, tra Musical Examination must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)	· · · ·	
yla	should be nd Mental marked c	Tof	Charles Henry Weisman				Augu	ısta	Wood				
Maryland	permit. Pages 1 and 2 should b Depertment of Health end Menis Importent: If Item 27 is marked eny injury or other traumatic e one.		19a. Informant's Name/Relationship (Type, Print) Joan Cranford (Niece)						Route Numbe				
	Heall tem 2 other			Ob. Place of Dispo	sition (Nan	ne of			ate		ation - City		
ē	Pages ent of nt: if i		1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei Our Lady				Cem.	6/18/07				Maryland
Baltimore,	permit. Depertm Importa eny Inju		21. Signature of Funeral Service Licensee	22	2. Name an	d Addres	s of Facilit	y Ra	usch Fi	nera	al Hon	ne,	P.A.
8	89 5 8	1 3	5th 5. 5ith						d, Port F		ic, Ma	ryla	nd 20676
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory arr	est,		l li	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	bic	Sh	OCI	K_						Donset and Death
	/Medical Examiner		Due to (or as a co	nsequence of):	l		Fce	:/					1 294
		e	Secuentially list our citions if any, leading to immediate Due to (or as a co	nsequence of):	10-00		ice	10				+ '	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	emen	44							>	142
90,	Attending Physician: The law requires that the death certificate be executed redeath. The this certificate has been signed by the etter this certificate has been signed by the ettering physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Ä	resulting in death) Last Due to (or as a co	nsequence of):									
8760,	cate b	dical	d										
9 x	certifi nding use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of p	regnancy					-	25	3d. Date of o	talivan	
Box	death d for u	clar	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time		Ectopic pre Other (spe					2.	Month		ay Year
P. O.	by the	hys	9 Unknown 9 Unknown										
	res that the death certific igned by the ettending p be detached for use as	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying ca	use give	n in Part I.						cause of death?
ord	w requir been si should I	eted	·HTN						1 U Y	es 2□	No 3∐	Probab	oly 4 Monknown
Records,	has t	Completed	•						24a. Was a autops perfor	ا م ۱	24b. Were prior t death	o comp	sy findings available of cause of
	in: Th		25. Was case referred to medical						1 Yes	2 No		es 2	□ No
<u> </u>	ysicis is cert direct	To Be	examiner?	2 ER/Outpatien	t 3□ DO	A Othe			Check only or		□Other (Si	nacify)	
0	ng Ph Iter th neral	L.	27. Manny of Death 1 Natural 5 □ Pending (Month, Day Ye			3c. Injury Work			8d. Describe h				
Sio	eath. or: Al	catle	2 Accident investigation 3 Suicide 6 Could not be	,,,	М		es 2□ì	No					
Division of Vital		Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S	At home, farm, str. pecify)	eet, factory	, office		2	8f. Location (S City or Tow		Number or	Rural F	Route Number,
_	the Hospitei or hin 24 hours afte the Funerei Dir mpletely filled in		29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death	n occurred a	at the tim	e, date and	d place, a	nd due to the c	ause(s) a	ind manner	as stat	ed
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or in	vestigation,	in my op	inion, deat	h occurre	d at the time, d	late and p	lace, and d	ue to th	ne cause(s)
	To the Within 2 To the comple	Σ	29b. Signature and title of certifier			License		10	2	9d. Date	signed (Mo	nth, Da	iy, Year)
	4					00	622	15		6	12	07	-
		1	30. Name and address of person who completed cause of death Suresh H. Patel, MD 22650 C	(Item 23a) (Type, Cedar Lan		rt,	Leona	ardto	wn, Mar	ylar	nd 206	550	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature					,				
	Registra	ar	JUN 1 8 2007 Beaut 15	Book	*								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:25A 12 Theodore June 2007 Phillip Wolan. Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F Yrs. 79 Nov. 15, 1927 Massachusetts 010-20-9436 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 21 No Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 20882 U.S.A. 23609 Dixie Ridge Court Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items; any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever în U.S Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ¬Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 📈No Specify: White Specify: WWII Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Elementary/Secondary (0-12) College (1-4or 5+) Service 12 <u>Mail Handler</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Theodore P. Wolan, Sr. Beatrice Moriarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0882 19a. Informant's Name/Relationship (Type. Print) 23609 Dixie Ridge Court, Gaithersburg, Maryland Teresa Schlee - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/07 4 ☐ Other (Specify) Hillsboro Mem. Gardens Brandon, Florida 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Sign ture of Funeral Service Lisensee ms 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebravascalar /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and bunial-trai Due to (or as a consequence of): physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stenosis 1 Yes 2€ No 3 Probably 4 Unknown ackinson 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No demenna 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division or Vital Records,

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. Medical

State Registrar 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

74 Motuncel. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

18111 Prince Philip Dr., Olney, Maryland

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Ata Motamedi T'5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Hassan Arfaian /Medical May 16. 2007 4:58 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-08-3229 1 XM 2 ☐ F Months Director 86 5, 1921 Mar. Iran Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Montgomery Rockville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be 5809 Nicholson Lane, # 1516 20852 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iten any Injury or other traumatic event, the M-dical Examiner and. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Military 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tuba "Unknown" Hossein Arfaian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koorosh Arfaian - Son 8905 Holly Leaf Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parklawn Cemetery 5/19/2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** prostate Cancer year /Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): the burial O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Division or Vital Records, P. FAIANOHassan Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA the funeral di Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No after death death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar GEORGE

31. Date filed (Month, Day, Year)

JUL 0 2 2007

A SOTOS, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician John Robert Alexander PM June 2007 1803 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) Aug. 31, 1933 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 □ F Aug. 73 Maryland Director 212-30-5768 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2 ☐ No Director MD Baltimore Baldwin 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 4454 Carroll Manor Road 21013 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No white Specify: þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Refuse Collection Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Ignatius Alexander Margaret Agnes Tahney ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4454 Carroll Manor Road; Baldwin, MD 21013 Shirley H. Alexander / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sweet Air, MD St. John Lutheran 6/30/07 ☐ Other (Specify) 4 □ Donation 1050 York Road 21. Signature of 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemia **Physician** 40days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Covonary Sequentially list conditions, in a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to for as a consequence of) as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of performed? Yes 2 No After this certificate 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2X No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) June 27, 2007 AT-2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Williams

31. Date filed (Month, Day, Year)

Union

JUL 0 2 2007 Mag. =

DHMH 17 Rev 1/2001

Memorial

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 1045 a M **Physician** barnes 38 une 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death Examiner Greneral Baltimore NIK Maryland 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 M 2 □ F march Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must he navitant once. 10a. State 10b. County 10c. City, Town or Locetion 1 Pres 2 No **Funeral Director** imore 10f. Zip Code 10g, Citizen of What Country 10e. Street end Number Madis 2121 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**O Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ack Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aborer Sth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina J. Barnes 312 Ave, Balto, md, 2121 madison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 □Cremation 3 Removal from State MT. Carmer -07 √5 ☐ Other (Specify) 4 ☐ Donation/ Cam 21. Signature of uneral Service ween e 22. Name and Address of Facility 270 Fred HILTON PROS Freneral Home eto. md 21229 marc 23a. Part. E et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate La se (Final disease or Indition Typer Kalemia **Physician** disease or indition resulting in death) /Medical Due to (or as a consequence of) End strackenal Dis Examiner hemodialosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Sephicemia physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached f 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Secondary Hyperparathyroidism 4 Unknown 1 TYes 2 No 3 Probably Be Completed Heart failu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has the lirector, page 2 s autopsy pertorme disorder Seizure 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Inpatient within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) .50 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Midi, M.O. 2000 in Baltimore St. Baltimore

State Registrar 31. Date filed (Month, Day, Year)

0 2

DHMH 17 Rev 1/2001

32. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Day **Physician** Albert Louis Bierman, Jr. 26, 2007 1:30 A /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 732 Essex Avenue Essex Baltimore If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months 17 M 2□ F Days Hours Director 212-18-4098 86 April 12,1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 732 Essex Avenue 21221 S. A. items 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2 No 1942 − If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 Divorced White 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 **Owner** Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert L. Bierman, Sr. ပ Frances Bayer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanore Jane Bierman (Wife) 732 Essex Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens | 06/30/2007 | Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Scheni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or s a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 1 Yes 2 No 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Inatural 5 Pending investigation Injury n 24 hours after death.
he Funeral Director: A
pletely filled in by the fi 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fun

completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUME 28 2007 100835 8 Weilg.D. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HARFOUN (COBP 903 31. Date filed (Month, Day, Year) State Registrar

07-04627	
David Karl	Dollhuret

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene David Karl Bollhursi 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month June 17, 2007 Medical Examiner 1200 hrs David Karl Bollhorst 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 4115 Loch Lomond Drive **Baltimore County** Nottingham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian Months Days Hours Min Director Country) MD 216-82-2263 34 1 X M 2 F 1973 29 . Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2X No Baltimore N/ADirector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4115 Loch Lomond Dr. 21236 uneral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 屲 Yes. Give Yea Yes 2 X No specify: White Widowed 4 Divorced 3 Specify: "natural" ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) nore, MD 21215-0036
ages I and 2 should be filed within 72 h
nt of Health and Mental Hygene.
It: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 72 Loan Officer Mortgage Co. 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) umatic event, Be Vina Ann Blessing Donald K. Bollhorst ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4115 Loch Lomond Dr., Nottingham, Md. Donald K. Bollhorst/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State fimore, permit. Pages l Department of H Important: If i crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6/22/2007 4 Donation 5 Other Specify: Bayview Crematory Baltimore, Md. 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road, Nottingham, Md. 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physicia<u>n</u> Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and transiv Physician/Medical AMENDED, 27, 28a-f, perME, g869, 7/5/07 TT X UNPENDED the attending physician ed for use as the burial Records, P.O. Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, isigned by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 2 No 1 V Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred

24 hours after death.

Funeral Director: After this certifi Division of Vital the within 24 hours a To the Funeral I

Certification: 2 3 29a. Certifier 1 Medical one)

Natural Pending FND 6/17/2007 Accident

Suicide

29b. Signature and title

Homicide

Investigation 6 X Could not be determined

(Specify) found at home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated

FND 11:55 art

Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

29c. License number

O.C.M.F.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

4115 Loch Lomond Dr. Nottingham, MD 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

June 18, 2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

31. Date filed (Month, Day, Year) State Registra

Patricia Aronica-Pollak MD.

Registrar's Signature ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Ø

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 0315 AM arole Bowen 9 2001 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore 5. Social Security Number Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔏 F Maryland 213-26-6346 76 Director Usual Residence of Decedent the Maryland 10a. State 10c. Cify, Town or Location 10d. Inside City Limits 10b. County or 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ral", or items 23a or Examiner must be r 21228 USA Funeral 103 Starhill Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 X Widowed 4 □ Divorced "naturai" other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Director of Volunteer Services 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Freda Grace Stuckey Edgar John Altvater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. 6181 Stephen Reid Road; Huntingtown, MD Steven Johnson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, Maryland Crest Lawn Mausoleum 7/3/2007 4□Donation 5KOther (Specify)Entombment 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cerebrovascular acciden /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate ha 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours aft

To the Funeral D

completely filled in

Medical

31. Date filed (Month, Day, Year) State

(Check only

29b. Signature and title of certifier

Melnaehan 22 32. R

Name and address of person who compileted cause of death (Item 23a) (Type, Print)



5.

Registrar DHMH 17 Rev 1/2001 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

St.

AU41764351416779

29d. Date signed (Month, Day, Year)

Baltimore MD 2120,

06/29/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	larylan	d / Dep		of Heal	Ith and I	Mental Hyg	_	17	21131
12	Dhusiai		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic			Daniel Jos	seph	Bi	edronsl	ci,	Sr.	June		2007	11:30 M
	Examir		4a. Facility Name (If not institution, g)		4b. City, To	wn, or Loca	ation of Death)	4c. County	of Death	
20	Alley of the second	À	1630 Gray Ha					Dunda				Balti	
	Funeral		,	10M 20E		iast birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Day			ace (State or Foreign try)
1.	Director		214-24-9295 Usual Residence of Decedent	78	3	113.				Sept.	18,1928	Mar	yland
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	0d. Inside City Limits
	Man,	tor	Maryland Bal	timore						Dunda1k			1 ☐ Yes 2√∑ No
	r 28a	Director	10e. Street and Number				10f. Zip C	ode			10g. Citizen of V	What Coun	try?
	23a o		1630 Gray Hav	en Court				21222	2		United	Stat	es
	dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Deceder	t of Hispan	nic Origin? (Specifican, Puerti	pecify Yes or No- o Rican, etc.)	- 14. Rac	e - Americ	
98	or It	y Fu	1 ☐ Never Married 2 ☑ Married	1 GYes 2 If Yes, Give			1 ☐ Yes 25				Specify		510.
8	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f ehow disal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	Kore	ean						Wh	ite
21215-0036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "naturel", or Iteme 23a or 28a-f show other then "naturel", or event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual (kind of work DO NOT use	done durino	most of wor	king	16b. Kind of Bu	usiness/Inc	lustry
12	filed within Hygiene. other then ent, the Mer.	mc	Elementary/Secondary (0-12) 10 Years	College (1-4or	5+)		Longsh	,	n		Dogle	Work	
9	filed Hygid other ent,		17. Father's Name (First, Middle, Las	st)	4-00		JOHN SIN			ne (First, Middle,			
<u>a</u>	should be nd Mental marked o matic eve	To Be	Louis Biedrons	ki					Franc	ces Buch	acz		
Maryland	2 should and Men le marke sumatic		19a. informant's Name/Relationship	(Type, Print) Wil	e	19b. Maili	ng Address (S	Street and N	Vumber or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
	5 = 12 ±		Mrs. Victoria G	. Biedrons	ski	163	O Gray	Haver	n Ct. I	Dundalk,	Maryla	nd 21	.222
ore	ges 1 ar it of Hea if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Removal from State		Place of Disponentery, cre	sition (Name natory or othe	of er place)	I	Date	20c. Location -	City or To	wn, State
Ë	Pag ment ant: I		Donation 5 Other (Spec		Sac	cred H	t. of i	Jesus	Cem. (6/30/200	7 Dund	alk,	Maryland
Baltimore,	permit. Pages Department of the Important: If Ite ony injury or of once.		21. Signal e of Funeral Service Lie	en300	10) 2	2. Name and . Duda-Ri	Address of 1	Facility ineral	Home of	Dundal	k, In	C.
	0 □ ≥ • 0	4		<u>a</u>	<u>e</u>		7922 W:	se A	ve. Di	undalk,	Marylan	d 212	22
			232 Parts. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the deat line.	h. Do not en	er the mode of	of dying, suc	ch as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Sma	11 C	-ell L	UNS	Can	cer				1 year
	/Medical Examiner		1	Due to (or a	s a conseq	uence of):							,
		<u>-</u>	Sequentially list conditions,	b. Due to (or a	s a consuu	wence of):							
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ć	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or a	s a conseq	uence of):							
760,	ys e	cal	•	d.									
99	ntifica ng ph as th		IEEEWA E										
Вох	eath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic preg	nancy				te of delive	
	The law requires that the death certifica lie has been signed by the attending ph rage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a	at time of d		Other (spec				Мо	ntn	Day Year
P.0	that the		Part II. Other significant conditions	contributing to death	but not roc	ulting in the u	ndorhina onu		Doel	23a Did to	phaces use cont	ribute to th	e cause of death?
ds,	signe d be c	d by	artii. Othor signimum contactions	contributing to death	Dat Hot 185	diding in the d	noenying cau	se diveri in	rditt.				ably 4 Unknown
O.	w require been si should t	etec								-			
Records,	has has	Completed								24a. Was autop	sy	Were autoportor to con death?	ssy findings available npletion of cause of
a										1 ☐ Yes	2 400	Yes	2□ No
Vital	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital:	inst 2	ER/Outpatie	a 7 7 704	Other		th Check only o		(0. (
o	ding Physi h. After this c funeral dir		27. Manner of Death	28a. Date of Inj	ury	28b. Time o		Injury at Work?	□ Nursing H	ome 5 Resid	now injury occurr		")
ion	Attending or death. ctor; After by the fune	at lo	1 Natural 5 Pending 2 Accident investigati	(Month, D	ay Year)	Injury	м	Work? 1 ☐ Yes	2 □No				
Division	I or Attendi efter death. Director: A I in by the fu	E L	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	njury - At ho	ome, farm, st	eet, factory, o	iffice		28f. Location (S City or Tow	Street and Numb	er or Rura	Route Number,
ā	ospital or A hours efter uneral Dire ly filled in b	Certification:		Building, e	nc. (Specin	y /				City of You	WI, State)		
	I 4 II 0	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the bes miner: On the basis and manner s	ot examina	wledge, deat ition and/or in	n occurred at vestigation, in	the time, da my opinion	ate and place n, death occur	, and due to the or rred at the time, o	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. t	icense num	nber		29d. Date signer	d (Month, I	Day, Year)
))	PHYS	ICT	AN	Do	20 58	3475	5 =	JUNE .	27	2007
	2 1		30. Name and address of person wh				Print)						
4	511		PHILIP WIVATP				PIZCPI	+IAI	ROAD	SULTE	208,64	CTIA	CUE NOTISS
3	Sta		31. Date filed (Month, Day, Year)	29	trar's Signa	ture	P			•	*		
42	Registr	al	JUL 02	LUUI LA	100 0	Cio da	Bell !						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 9:00 pM Mary O. Benner June 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4113 Mary Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)

Wonths Days Hours Min. Feb. 19,1916 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign 1 M 2 SF Months Maryland 91 Yrs 213-14-8546 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h Counts 1KYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 **USA** 4113 Mary Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary 11 Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Owens Mary Kenny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 500 Talbott Avenue Lutherville, MD 21093
ca of Disposition (Name of Date 20c. Location - City or Town, State Mary Alice Parson- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 7/2/07 Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Se ature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 23a. Part. Enter the disease, shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3-6 months retastatie S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Tes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ≥ No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Tyes 2 □No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, fo the Hospitel or Attending Physician:

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, tha Madical Examinar must be notified a once.

Physician

/Medical **Examiner**

the attending physicien and hed for use as the burial-transit

signed by the ail

peeu

this certificete has

Baltimore, Maryland 21215-0036

24 hours

within 2 To the

State Registrar 31. Date filed (Month, Day, Year) 0 2 2007

29b. Signature and title of certifier

29a. Certifier

Medical

o ampleted cause of death (Item 23a) (Type, Print) mo 7505 Osler

32. Registrar's Signature

Brie, Ste 302, Towson, MO 2120 4 Gorale

Recrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

016587

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 6:15 21 Emerson Laumont Cary June 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Spring Silver Holy Cross Hospital 8. Date of Birth (Month, Day, Year)
Jul 18,1952 If Under 1 Year | If Under 24 H 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Virginia 54 230 72 8260 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 Pres 2 □ No Directo Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 USA 1916 Wallace Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of College (1-4or 5+) Elementary/Secondary (0-12) Transportation 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis Dillard Carol Cary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1916 Wallace Ave Silver Spring, MD 20902 Karen M. Carey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of I Important; If its any injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State Jun 29 07 Cheltenham, Cheltenham Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Veterans Funeral Care, Clearwater, FL 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. E. the Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes Kidney Failure, Hypertension, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes, Liver Failure autopsy performed? Yes 2 No has 2 No 1□ Yes funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 3 00A 2 ER/Outpatient 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Hospital or 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

To the I within 2

144

29b. Signature and title of certifier

Gaby Tesfaye

31. Date filed (Month, Day, Year)

30. Name and address of person who complet a cause of death (Item 23a) (Type, Print)

02

. D.

32. Resistrar's Signature

29c. License number

D52555

1500 Forest Glen Rd Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

June 22, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #20b, perFH, g869, 7/2/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12,2007 Month **Physician** Curley Rebecca 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner heisterstown Future Care Baltimore 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 1 F Yrs Director May 10, 191 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Baltimore heisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Maple Ridge Boad USA Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1Stodian Baltimore Cite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Minervia unhacun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Daughter 144 Monte Ridge Rd Reisterstern, mo 21136

20b. Place of Disposition (Name of Cemetery, crematory or other place)

3 Removal from State

20c. Location - City or To Cam h. Opher
20a. Method of Disposition 20c. Location - City or Town, State 22. Name and Address of Facility Variation C. Green function 5 eroses 23a. Part 1. Entertule disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 8728 Liberty And Mandalistam miD 21133 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if an . leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 6353 Jan, 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reistertown MD Shahba2 Mandana 31. Date filed (Month, Day, Year) 62. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	aryland /		tificate of t			leg. No.	300 300	
П	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Gary Crossman			-			June			2:01 PM M
	Examir	er	4a. Facility Name (If not institution, give				-	Location of Death			County of Death	
			4005 Bayside Ro. 5. Social Security Number 6. S		e (In yrs. last	hirthdayl	Snow H		8 Date of Birtl		rcester	nplace (State or Foreign
	Funeral Director		071-38-2893	X M 2□ F	60	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day June 3,	194	Cou	v York
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	MD Worce	ster	S	now I	Hi11					1 ☐ Yes 2 ☐ No
	28e	rec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	untry?
	13a o	Funeral Director	4005 Bayside Roa	d				21863			USA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No-	1	4. Race - Amer Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or iteme 23s or 28s-f show svent, I'm Medical Eraminar must be notified at	b	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🔯 1 If Yes, Give Year or Dates:	No		Yes 2∏ No		, ,		Specify: wh	
2	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation	10	(Give	lent's Usual Occup	during most of wor	kina	16b. Kir	nd of Business/l	Industry unk
2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT use retired	1)				
2	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)	1		WOO	d carver,	18. Mother's Nam	- /First Middle	Maidas	Sumamal	
and	ntal H	Be	Frank Crossman						11a Dalı		Sumame)	
Ž	should be and Menta marked umatic sy	٦	19a. Informant's Name/Relationship (Type Print)	1	9h Mailin	g Address (Street				Town State 2	in Code)
Σ	as 1 and 2 should to of Health and Ment litem 27 ie marked rother traumatic a		Jean Crossman/sp		1		Bayside				21863	,,
ē,	tem tem		20a. Method of Disposition	Juse	20b. Place	of Dispo	sition (Name of natory or other place	1 1	Date Date		cation - City or	Fown, State
Ö E	Pages nent of i ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif		Ceme	жөгү, сгеп	natory or other plac	;e) ; 				
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licer	1500	ector	St	Name and Addre	omy Board	1 655 W.	Ba1	timore	Street
	40240		23a Part Enter the distance or corr	plications that caused	the death 5	Ba	<u>ltimore,</u>	MD 2120	or resourations ar	roet		Approximate
			23a. Part. Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death
>	Physician /Medical		disease or condition resulting in death)	a Non-	5nul	(ell ca	-c:100	e st	20	11	gno-17hg
	Examiner			Due to (or as	a consequen	ce or _j .						
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	à consequen	ce of).	**********					
	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
o,	tificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):						
68760,	ate b hysic the b	edicai		_ d								
			IF FEMALE:	220 Hugo outcome	of programme			-				
Box	eath certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal de	ath 3□	Ectopic pregnancy Other (specify)	,		2	23d. Date of deli Month	rvery Day Year
o.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by Physician/N	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	tuile of deati	. 3						
Q.	that the detail	된	Part II. Other significant conditions of	ontributing to death b	ut not resultin	g in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
Records,	uires sign ld be								1950	es 2[□No 3□Pro	obably 4 Unknown
Ö	w require been signature	lete							24a. Was	an	24b. Were au	topsy findings available
Re	he lav e has age 2	Completed								rmed?	death?	completion of cause of 2 No
Vital	ysician: The is certificate hadirector, page	a u	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o	2/20No	1 105	20140
_		To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2□ER	Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	lence 6	G □Other (Spec	cify)
0	Attending Physician: r death. sctor: Atter this certific by the tuneral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	now injury	y occurred	
<u>0</u>	endir eath. or: Al	atic	2 ☐ Accident investigatio	n				Yes 2 □No		_		
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (S City or Tox			ural Route Number,
	ours a erai C		200 Codifier 1 Codifies D	eminion. To the best	of more ton contin	due desait	e constituent on the co	no. Yet a new plan-	and the fit the	ami in vina	man manager of the	what is d
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: Alter th completely tilled in by the funeral	Medical	29a. Certifier 1 Certifyin J Pt (Check only 2 Medical Exar	nysician: To the best niner: On the basis o and manner st	f examination	and/or inv	vestigation, in my o	pinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
	omple	Me	29b. Signature and title of certifier	/			29c. Licens	e number		29d. Date	e signed (Monti	h, Day, Year)
	- 5 - 0		MCN/	_ n.	0.		0	30690		- د <i>ت</i>	. 26	2000
			30. Name and address of person who	completed cause of o	leath (Item 23	a) (Type,	Print)				,	
			James E. MA	ATIN N	.0.	145	E. Co	10011 5	1. 5-1	:56	org, M	D 2180,
	Sta											
3	Regist	ar	31. Date filed (Month, Day, Year)	Ul Bleeve	, B	Gos	400				saamess	
DILL	44 17 Day 1/2	004				7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g869,07,02,07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month PM au atron 2007 Vlegan /Medical 4c. County of Death 4a. Facility(Warne (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins Baltimore Cit Johns Baltimore 1.5 Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🂢 F 199-68-6217 4/7/1986 Director MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No MD BALTIMORE Director PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8537 CHESTNUT OAK ROAD 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines 1X Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: þ WHITE 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COUNTER CLERK CASA MIA'S 8TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN LEBO CAROL CATRON ပ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8537 CHESTNUT OAK ROAD BALTIMORE, MD CAROL CATRON/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/4/2007 COCKEYSVILLE, MD GAPDENS 2. Name and Address of Facility 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician brain ounexic /Medical Due to (or as a consequence of): EXAMINER Examiner cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examiner requires that the death certificate be executed ischemia Cardiac and burial-trar CERTIFI Due to (or as a consequence of): the attending physician P.O. Box 68760 Circulation 40 malous Physician/Medical terial the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 SLive birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 200 9 Unknown Jan ugra signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 ☐ Probably 1 ☐ Yes 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coagulopathu he law certifica e has autopsy perform Yes 2 No Division or Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient 2 ER/Outpatient 3 DOA Certification: To After this filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 TYes 2 TNo 2 Accident after death Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Notfe Street, Boultimore, Maryland

30. Name and address of wrson who completed cause of death (I em 23a) (Type, Print)

K. Rhodes

31. Date filed Month, Pay Year 2007

North

32. Registrar's Şignature

Please Type or Print in Black Indelible lok. Ensure All Copies Are Legible. 30 per dvr g869 7-2-07vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 Month **Physician** 12:16 ^{P м} 28, June Julia Robertson Casto /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year 1920 Alabama Min 1 □ M 2 🗓 F 10, Nov. 86 Director 417-18-1089 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1XXYes 2 □ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 4905 Rockingham Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritai Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If frem 27 is marked other tra-any Injury or other transmatic. Legal Secretary Law Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SallyPlume Sanders Thaddeus Curtis Robertson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4905 Rockingham Lane Bowie, MD 20715 Charles Conrad Casto/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/1/07 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cirrhosis **Physician** Storage month disease or condition resulting in death) /Medical Due to (or as a consequence of obstructive Pulmonary Examiner Chronic Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed a and Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Dav 4 ☐ Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 9 ☐ Unknown signed t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 101 nows 2 No 3 □ Probably 4 □Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ∏Yes 2 ∏No М 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 1 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Sign

Convalescen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** /Medical Sharon Coppage June 28 2007 2:10 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore <u>St. Joseph Medical Center</u> Towson Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 27,1952 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 54 Director 218-58-9850 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 💢 No Directo Baltimore Sparks Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 21152 U.S.A. 1 Hunt Farms Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ε. Schuster Frances Manns ပ John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald E. Coppage Sparks, <u>Husb</u>and Hunt Farms Court Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7-3-2007 Timonium Maryland 21. Signature Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 21204 Towson, Maryland BU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of d with (Item 231) (Type, Print) H:11c7. Lutherv: 11e, MD 21093 MD 6 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2007

JUI 02

Physician /Medical Examiner **Funeral** Director death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Funeral じreswell, Helen Baltimore, Maryland 21215-0036 Completed by of Health and Mental Hygiene. Be Pages 1 and 2 should be မ

Physician /Medical Examiner

permit. Pages Department of Important: If it any Injury or o

physician and s the burial-trans attending p as ed by the a signed t cate has t page 2 s certificate I this

Box 68760,

P.O.

Division or Vital Records,

The law requires that the death certificate be executed l or Attending Physician: After t death. Funeral Director; stely filled in by the Hospital 24 hours To the I State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28 28 11:20 AM 06 2007 Helen M. Creswell 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Franklin Square Hospital
5. Social Security Number 6. Sex 7. Kosedale Center 8. Date of Birth (Month, Day, Year)
July 23,1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 □ M 2 🙀 F 216-07-9967 Maryland 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Over1ea Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA 4715 Mawani Road 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loyal T. Ortt Josephine Hartman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Penny Quinn- Niece 25 Broadbridge Road Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 6/30/07 Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Patt1. Enter the digeal shock, or heart failure. Onset and Death Immediate Cause (Final disease or condition resulting in death) ZMU Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 1☐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 NO 1 patient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 6/28/2007 DOOG4755. VASILIADES. M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore MD 21237 Dr. Minus Vasilia des 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** AM 6:10 Eleanor Difonzo JUNE 26 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center 5. Social Security Number | 6. Sek | 7. Age (In yrs. last birthda) Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🔀 F 89 Feb. 11, 1918 Delaware Director 221-07-4858 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Kingsville Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 9 Country Hill Court 21087 <u>U. S. A.</u> Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify ò 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DuPont 10 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmela Lentini Nicholas Cardillo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Country Hill Court, Kingsville, Maryland 21087 Mario DiFonzo (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 06/29/2007 Wilmington, Delaware Cathedral Cemetery 22. Name and Address of Facility Schimunek Funeral Home 21. Signature 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner WEEKS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entire U. January Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached in 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Plabetes hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Atrial tibrilla hon autonsy performed? 1 Yes 2 No certificate Arteny Disease Coronary or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🔍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29a. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE ST. 22 BATTIMONE, MD 21201 i D

Registrar DHMH 17 Rev 1/2001

State

BRIGIT

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	partment ertificate			and M		iene	0.7	211112
	Physici	an	1. Decedent's Name (First, Middle, Las-	1)						2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Tessibell Werner							June 25,	2007		2:00 A M
ř	Examin	er	4a. Facility Name (If not institution, give	street and number)				Location o	f Death		th .		
			1036 Hazel Lane 5. Social Security Number 6. Se	7 499	(In yrs. last birthda		Ai	f Under 2	24 Hrs	9 Data of Birth		Harfo	ord hplace (State or Foreign
	Funeral Director				88 Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, May 30,	1919	Pen	npiace (State of Foreign nuntry) nsylvania
			Usual Residence of Decedent		110							1	
	nylan how	_	10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Ba-f	cto	Maryland Harfor	d	Bel Air								1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number			10f. Zip					og. Citizen o		ountry?
	e 23e	erai	1036 Hazel Lane	12. Was Decedent E	Type in U.S. 1		014		-:-2 /5		U.S.A		nican Indian,
	fter d	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 N		If Yes, speci	fy Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ack, White	
036	ers a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2	No No	Specify:			Spec	ify: W	Mhite
5-0	72 hours after death with the Maryland naturel; or iteme 23a or 28e-f ehow dical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. De	cedent's Usual	Occupa	ation	of work	ina	16b. Kind of	Business/	Industry
2	Athin ne.	upl	Elementary/Secondary (0-12)	College (1-4or 5	+) life	. DO NOT use	e retired,) -		9	_		_
2	filed within Hygiene. Ither then "	ပိ	17. Father's Name (First, Middle, Last)	2	Cla:	lms Rep	rese			(First, Middle, N			Company
and	d be sontal	Be c	Norman B. Werner							J. Hay	naiden Sunne	ime)	
Maryland 21215-0036	should ind Men ind marke	To.	19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	iling Address	(Street a			al Route Number,	City or Tow	n, State, Z	Zip Code)
Š	and 2 selth a n 27 is		Janice Dodge Truz	zolino (Da	ug.) 103	36 Haze	1 La	ane Be	el A	ir, MD 2	1014		
ore,	of Heel		20a. Method of Disposition		20b. Place of Dis		e of	9)	, [Date 2	20c. Location	- City or	Town, State
<u><u>Ĕ</u></u>	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heelth and Mental Hygiene. ortant: If item 27 is marked other than "naturel; or iteme 23a or 28a-f show injury or other treumatic event, the Madical Examination at the notified at all. 8.		1 ☐ Burial 2 📉 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Bayview				6/25	707 B	altimo	ore,	Maryland
Baltimore,	permit. Pages 'Department of Himportant: If ite eny injury or of ones.		21. Signature of Funeral Service Licens Buan G. W.	illem	-	22. Name and			Scn	imunek F 1 Rd Bel			e of Bel Air 21014
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do not a								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	Kenal	Fall	ure						Five 4 ears
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1	1	4					T
ı	- Xumino	_	Sequentially list conditions,	b	CGrona consequence of):	ry AT	TCI	y PI	seq,	1e			tiveyages
	red nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 to (0, 23 2	consequence or,	J	<	J					/
<u>,</u>	execunand nandial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):								
8760,	cate be executed physicien and the burial-transit	cal		d									
89	ntifica ng ph as th		IF FEMALE:										
Box 6	Physicien: The law requires thet the death certifics this certificate has been signed by the attending propertal director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth		3 □Ectopic pre	gnancy				1	ate of del	
O.	the at	sici	1 Tyes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	Other (spe	cify)				N	ionin	Day Year
о. О.	thet the	Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the	underlying ca	use nive	n in Part I.		23e. Did tob	acco use co	ntribute to	the cause of death?
Records,	uires sign d be	d by	× 1			, , , , ,	· · ·				s 2□No		obably 4 Unknown
Ö	w require	Completed								24a. Was ar	24h	Were au	itopsy findings available
Be	The la	dwo			-					autops; perform	ned?	prior to death?	completion of cause of
ţ	en: Tifica	0	25. Was case referred to medical					26. Place	of Death	1 Yes 2	7 (No	T U Y OS	2 □ No
>	nysici nis ce i direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpat	ient 3 DO	Othe	v.c.		me 5 Reside		ther (Spe	cify)
n 0	ng Pi		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur	of 28	c. injury Work	at ?		28d. Describe ho	w injury occi	urred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		es 2□N					
Division of Vital	tal or At rs after c al Direc ed in by	Certification;	4 Homicide determined	28e. Place of Inju building, etc	iry · At home, farm, c. (Specify)	street, factory,	office			281. Location (Str City or Town		nber or Ru	ıral Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	29a Certifier 1 Arritying Phy (Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination and/or	ath occurred a investigation,	it the tim in my op	e, date and inion, deat	d place, i th occurr	and due to the ea ed at the time, da	usu(s) and i	, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title, of certifier	C . 1.				number	, .				h, Day, Year)
			· Runna	My all M	0		113	364	2		JUNE	25/	2007
5			30. Name and address of person who co	ider in	154 Hickory	e, Print)				/Ar	MD	2/0	014
	Sta Registr		31. Date filed (Month, Day, Year) / JUL 0 2	32. Rigistin	r's Signature	foot	0						
			· · · · · · · · · · · · · · · · · · ·			W .							

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral I

Certification: To nours after death.

neral Director: After this filled in by the funeral di Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

(m)

29d. Date signed (Month, Day, Year) 38246 JULY 2, 2007

8186 LARK BROWN RD, SHITE ZOI, ELKRIDGE, MD ZIO75 JOSEAH FE (336 M) MD

State Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTFM#20b, perFH, G869, // 6/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Alma Sells Douglas 29, 2007 2:00 P.M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Somerford Place Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Dec. 25, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 T F Maryland 88 216-10-2166 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 9757 Riverside Circle USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stella Wilt Earl Sells ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9757 Riverside Circle; Ellicott City, MD 21042 Ronald Douglas Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/6/07 Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 4 □ Donation 5 □ Other (Specify) Woodlawn, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signatur Frenal Service Licensee 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MACT UK.JARY ECK /Medical Due to (or as a consequence of): Examiner DEMENTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the hurial Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00025844 5411 OLD FREDERICK RD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2,229 BA-TRUCE MO

Registrar

DHMH 17 Rev 1/2001

State

1111 0 2 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:20 PM M June 17, 2007 /Medical Luther Dannie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2127 N. Dukeland Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 27, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 17 M 2□F South Carolina 85 248-20-4463 Vrs Director Usuel Residence of Decedent iii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hygiene. criment if Hem 23 is marked other then "natural", or iteme 23a or 28a-1 ehow njury or other traumatic event, ille Medical Energiae mast te nutitied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Yes 2 □ No MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2127 N. Dukeland Street 21216 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black Year or Dates: *41-42 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 orderly healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Simuel Danney Hattie Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roedell Myers/niece 325 N. Fremont Street San Mateo, CA 94401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) permit.
Deportra
Imports
any nju 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral S Director 655 W. Baltimore Street Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDI 4 OURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOYEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š ate hes been signi pege 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2) 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) ND 00059076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 6-1 RAL 31. Date filed (Month, Day, Year) Registrar's Signature State 0 2 2007 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar SHOALIZ

31. Date filed (Month, Day, Year)

ORIGINAL

Q21 N. ENTAN ST 8mle 308 BALTIMORE MID 2116.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 MHEATI .A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decement's Name (First, Middle, Last) Month Year 2007 **Physician** 02:30 PM 28 JUNE /Medical 4c. County of Death 4a. Faculty Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NA HOSPITAL BALTIMORE AGNES 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 □ M 2 K F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No **Funeral Director** timore MARYland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: AMERICAN Be Completed by 3 Widowed 4 Divorced Situation and Mental Hygiene.

Is marked other than "natural count, the Medical E. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use getired) 16b. Kin of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 10mestic 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) LOSSIE MAR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAHIMORE, MARY land 21215 annie Sisten saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State July 05,2007 Anschwie MARCIAnd 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility NANCY M. WATTER FUNERAL SERVICE STATE 3405 is FRANKIN STREET-BALLIMORE, HARYLAND 21229 21. Si per re of Funeral Service Licensee elece 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFLAMMATORY BREAST LA Physician YEARS /Medical Due to (or as a consequence of): Examiner METASTASIS 1.5 YEARS 10 LUNG Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy Division or Vital Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: ENT 1 Natural (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide l vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-14508 AWAIS MASODD, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S CATUA 900 AVE BALTIMORE, MD 21229 MASOCD 31. Date filed (Month, Day, Year) 32. Redstrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland / Dep	partment of Fertificate of			iene	07 2	1143		
3	Physici	an	Decedent's Name (First, Middle, Last) BARBARA		-	DORF	2. Date of Deat Month JUNE	Day	Year	Time of Death		
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		r Location of Death	<u> </u>	4c. County		J.30A		
			ARDEN COURTS 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		BALTIMORE If Under 24 Hrs.	8. Date of Birth	<u> </u>	9. Birthplace	ORE (State or Foreign		
	Funeral Director		212-32-5892	M 2 F 72 Yrs.	Months Days	Hours Min.	06/26/1	935	Country)	MD		
yland	at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or						nside City Limits		
he Mar	28a-f sh otified	ector	MD BALTIMORI	BALTIMO	10f. Zip Code		1	0g. Citizen of V		□Yes 2X No		
h with t	st be n	al Dir	10e. Street and Number 8911 REISTERSTOWN	ROAD	21208			U.S.A.				
3-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 N Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	B. Was Decedent of Head of the Head of th	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		e - American Inck, White, etc.			
2-C	"natur edicai B	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Gir	cedent's Usual Occur ve kind of work done . DO NOT use retire	during most of work	king	16b. Kind of B	usiness/Industry	/		
Z Z Z	giene.	dmo:	Elementary/Secondary (0-12)	College (1-4or 5+)		Ç <u>RETARIAL</u>		SOCIAL	SECUR]	TY		
and be file	ed oth	Be	17. Father's Name (First, Middle, Last)	DORF		18. Mother's Nam	ne (First, Middle, I		ne) IENKMAN			
arylic should	and Me is mark sumatic	T ₀	19a. Informant's Name/Relationship (Type		iling Address (Street		ıral Route Number			θ)		
6, Z	Health em 27 i ther tra		MARJORIE SCHENK / 20a, Method of Disposition	20h. Place of Dis	FDSON LAN				20852 City or Town, S	State		
altimor	nent of nt: If its Iry or o		1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ARLTNGTO AMUNO C	N ^m CHIZUK ^{pla}	^(ce) 06/2		BALTIMO				
Dall.	Departn Importa any Inju		21. Signature of Funeral Service Licent	· · ·	22. Name and Addre	TERSTOWN	ROAD - P	IKESVIL	LE, MD	21208		
*	*	83 T	23a. Part 1/ Enter the disease, of compli- shook, or heart failure. List only on Immediate Cause (Final	1.7			or respiratory arr	est,	Inte	roximate rval Between set and Death		
1	nysician Medical		disease or condition resulting in death)	Due to (or as a consequence of):	r Denu	VD 4						
E	xaminer	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
cuted	nd transit	Examiner	that initiated events									
8/6U, <	ohysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of):									
rifficate	ng phys as the	Medic	IF FEMALE:									
O. BOX by	been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	ey .			ite of delivery onth Day	Year		
ords, P.O	igned by	by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause giv	ven in Part I.		bacco use con es 2 □ No	tribute to the ca			
COLO	been s	leted					24a. Was a	n 24h	Were autopsy f	indings available		
The law	ate has page 2	Completed					autops perfori 1∐ Yes	med?	prior to comple death? 1 Yes 2	tion of cause of No 43 5 1 te 4 LIV		
Or VITAI	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Ott	hor:	ath (Check only on		10 11 10	elel I I was		
On Or	th. : After this e funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Inju		dome 5 ☐ Reside 28d. Describe he		ner (Specify)	SISTER CIVING		
DIVISION al or Attending	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (S. City or Town	treet and Numi n, State)	ber or Rural Ro	ute Number,		
Hospi	24 hour	ledical		siclan: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.								
To the	within To the comple	Mec	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signe	ed (Month, Day,	Year)		
			1 Tayman Whi	le my		7683		6/28/	っフ			
	O		30. Name and address of person who co	Similar 200 Rusks		2113	6					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32-Registrar's Signature	2222							

07-04424 Robert Frank Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ June 9, 2007 0000 hrs Medical Examiner Robert Frank 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 7906 15th Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 7. Age (In yrs, last birthday) 5. Social Security Numberunk 6. Sex **Funeral** Months Days Hours Oct 10, 1929 Country' 77 Director 1 X_M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 X No s 23a or 28a-f show e notified at once. Hyattsville Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 USA 7910 15th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) event, the Medical Ex miner must be White, etc. Armed Forces? unk 1 Never Married 2 Yes 0. white Yes 2 X No specify: Specify: If Yes, Give Year Widowed 4 Divorced "natural", ě 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life, DO NOT use retired) altimore, MD 21215-0036 unit. Pages 1 and 2 should be filed within 72 hor eartment of Health and Mental Hygiene. overlant: If tiem 27 is marked other than "nat ry or other traumatic event, the Medical Extra contraction of the contraction of Completed College (1-4 or 5+) Elementary/Secondary (0-12) unk unk 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State Burial 2 Donation & X Other Specify: in State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Departi Importi injury ervice Licensee 21. Signature of Euneral Serv RONALD Director cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or compl **Physician** Between Onset and fallure. List only one cause on each line Death /Madical a, Hypertensive Atherosclerotic Cardiovascular Disease complicated by Hyperthermia Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical attending physician a or use as the burial -UNPENDED AMENDED Box 68760 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the 1 be detached f 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö Yes 2 V No 3 Probably 4 þ σ. Completed Division of Vital Records. 24a. Was an 24b. Were autopsy findings available has been s prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 1 V Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Be Hospital: 1 Other; examiner? Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject exposed to extreme environmental Certification: FOUND Natural Yes 2 V No Pending temperatures Director: in by the f Jun 9, 2007 1509 hrs 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 7906 15th Avenue, Hyattsville, MD Suicide determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number June 10, 2007 O.C.M.E. andell 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 0543 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs. <u> Anne Arundel Medical Center</u> Anne **Arundel** 8. Date of Birth (Month, Day, Year, 02/11/1916 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 284F Hours 200-26-0921 91 Yrs. Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. An art If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XINO Florida Director Charlotte Punta Gorda 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ral", or items 23a or : Examiner must be n 29391 Turbak Drive 33982 USA Funeral 12. Was Decedent Ever in U.S. Armed Force ₹7 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No þ Specify: 3€XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Harry Knight Katherine Gomerdinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley McKenna/Daughter 1063 Rodgers Road, Churchton, Md 20b. Place of Disposition (Name of cemetery, crematory or other place)
Whitemarsh Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ott 1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/02/2007 Ambler, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final EL MON, A Physician disease or condition resulting in death) /Medical Due to (or as as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 ☐ Other (specify) signed by the at d be detached for 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 10 INSON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1⊟ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X** No Other: 1 🗌 Yes 1 Inpatient မ 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \underline{\square}$ Other (Specify) ours after death.

leral Director; After this filled in by the funeral dir 28a. Date of Injury (Month, Day 27. Manner of Death 1 Watural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) to completed cause of death (Item 23a) (Type, Print) NTA un 445 DEFENSE 176HWA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DIMILIATE D. AMORA

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ivia			ficate of			Reg. No.		61101					
I	Physici		1. Decedent's Name (First, Middle, Last)	Flyn	UN)				2. Date of De Month	ath Day 28	Year	3. Time of Death					
6.	/Medi Examir		4a. Fecility Name (If not institution, give si		-,-			1b. City, Town, or Lo			O Tof Death	71.00 7011					
Ĺ	Lxaiiiii	ICI	8800 Walther Blvd					Parkvi	lle	E	alti	more					
	Funeral Director			7. Age	(In yrs. last bir 4		f Under 1 Year fonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De June 7,	th 1913	9. Birthp Coun Mary	elace (State or Foreign try) I and					
	land ow II		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locat	ion				1	0d. Inside City Limits					
	a-fsh	ctor	Maryland Baltimore	9	Parkv	ille					1 ☐ Yes 🕉 📈 No						
	or 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	hat Cour	ntry?					
	23a Wat D	ia [8800 Walther Blvd				21234	1		USA							
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depentment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any figury or other treumatic event, I'm Medical Examiner roust be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2			s Decedent of H es, specify Cuba Yes 2XXVo	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blace Specify	k, White,	an Indian, etc. hite					
۲ ک	72 ho	eted	15. Decedent's Educa (Specify only highest grede	ation co <i>mpleted)</i>	16a.	Deceden	t's Usual Occup	ation during most of work	ina	16b. Kind of Bu	siness/Ind	dustry					
121	within	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)		NOT use retired retary)	•	City	City of Baltimore						
א ס	Hygie Hygie ther 1		17. Father's Name (First, Middle, Last)			Seci	ecary	18. Mother's Name	e (First, Middle.			barcillore					
<u>a</u>	id be ental ked o	To Be	John Thomas Mullin	Sr					therine Flanagan								
bailimore, maryland 21215-0020	nd 2 shou alth and M 27 is mar r treumat	-	19a. Informant's Name/Relationship (Type John N Flynn Jr					and Number or Rura Court #G									
g.	es 1 a of Heg		20a. Method of Disposition	mayal from Ctata	20b. Place of cemeter	Disposition	on (Name of ory or other place	е)	Date	20c. Location -	City or To	wn, State					
Ĕ	Pages ment of I ant: if ite ury or o		4 Donation 5 ☐ Other (Specify)	moval from State	New C							-					
Dal	Depentition Depending Services Services Services Depending Services De		Xennis Ness	New Cathedral Cemetery 7/3/07 Baltimore, Marylan Applonation 5 Other (Specify) New Cathedral Cemetery 7/3/07 Baltimore, Marylan Applonation 5 Other (Specify) New Cathedral Cemetery 7/3/07 Baltimore, Marylan 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 212													
			23a. Part1. Enter the disease, of complications shock, or heart failure. List only one	ations that caused cause on each lin	the death. Do r	not enter t	he mode of dyin	g, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between					
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	End	SHA			PD				Onset and Death					
		Jer	Due to (or es e consequence of): Due to (or es e consequence of):														
	death certificate be executed e attending physician end ad for use as the bunal-transit	ami															
Š	oe exe										1						
00/00	cate t	edical	that initiated events resulting in death) Last	C	ue to (or as a c	onsequen	ce of):										
		Σ	d.														
YOU.	death ce attendii d for use	icia	Part II. Other aignificant conditions contr	ibuting to death but	not resulting in	the unde	rlying cause give	en in Part I	23h Did	obacco use con	tribute to	the cause of death?					
	that the classification of the detection	y Physician/	Parti. Other aignificant conditions confi	ibuting to death but	Thorresulting in	Title unde	nying cause givi	en in raiti.				pably 4 Tonknown					
Vital necords,	The law requires that the death ce ate has been signed by the attending page 2 should be deteched for use	Completed by							24a. Wes perfo	an autopsy rmed?	ava	ore autopsy findings ailable prior to npletion of cause deeth?					
<u> </u>	The ate hi	Con							10	res 2. No	1 🗆	Yes 2□ No					
710	icien: The certificate rector, pag	a	25. Was cese referred to medical examiner?					26. Place of Death	(Check only o	ne)							
5	Physi this o	<u>٩</u>	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	spital: 1 ☐ Inpatien 28a. Dete of Injury		tpatient ime of		4 Indising no		dence 6 □Othe)					
5	ding I h. fune	tlon	1 Natural 5 ☐ Pending	(Month, Dey	Year) 260. In	njury	28c. Injury Work M 1□		zod. Describe r	low injury occurr	30						
	I or Attending Physicien: after death. Director: After this certific I in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ury - At home, farm, street, factory, office 28f. Location					Street and Numbern, Stete)	er or Rura	l Route Number,					
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)		examination end												
	Within To the	Me	29b. Signature and title of certifier	WA	QV	29c. Libense number 29d. Date signed (Month, Day, Yeer)				Day, Yeer)							
6	1		30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Type, Prin		ethen A	Cole	Park	ille	Wdzizsy					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Radistrai		bo	ach)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8 Per FH G869 7/02/07 a Thificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** GREEN 1220 PM MARY E 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town₂ or Location of Death **Examiner** Sinon Balt more N/A More If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days 1 □ M 2 🔼 F Months Min. Hours Yrs. 7-20-389 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edi al Exa<u>miner must be notified at</u> 1 Yes 2 No Director MD NIA Baltmore Cit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Seamon 21225 Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. <u>م</u> Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assisted lealth Care Provider 0 is marked other and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental)ames Cooper ٥ Mamie laryli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 Pofield the Balte, md, Micola Green 27 other Baltimore, Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages injury or 1 Burial 2 □ Cremation 3 □ Removal from State Forest Vet, July 3,2007 awings Mills, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Renered A. Copyright Funeral 21. Signature of Funeral Service Licensee Rurald 21242 220 Fred Hilten Pass. Balte Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician reumona Nosocama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sta 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a. Was an page 2 s autopsy performed? Yes 2. No 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 To the I complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Delvedere Baltimore MD 21215. MBBS 32 Segistrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

DIVISION OF VITAL HECOFIAS, To the Hospital or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be	ertification: To Be C	25. Was case referred to medica examiner? 1 Yes	Hospital: 1 _	Inpatient 2 ER/C	Outpatient 3[Time of Injury	DOA Other: 28c. Injury at Work?	4 ☐ Nursing Ho	(Check only one)	e 6 □Other (Spec	
NY VITAL MECC hysician: The law ri his certificate has be I director, page 2 shi	Completed	Lumbar	Spin	al Ste	0011	B .		24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of 2 No
COLDS, P w requires that been signed to should be detailed	þ	Part II. Other significant condition Perigher Lundar	ions contributing to	scular	in the underly	ing cause given in	n Part I.	23e. Did tobac	cco use contribute to	the cause of death?
the death certily the attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnancy birth 2 Fetal dea nnant at time of death nown		pic pregnancy or (specify)			23d. Date of del Month	very Day Year
68 / 6U, ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to statueurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Physicia /Medica Examine	ı	23a. Pan 1. Enter the disease, o show, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a(caused the death. Do each line.	y A	mode of dying, s	Disc.	or respiratory arrest	,	Approximate Interval Between Onset and Death
Baltimo		21. Si manu of Euneral of ryice Ronal d	Michiga	Director	Balt	imore, M	D 2120	1	altimore	Street
ore, No. 1 and of Health item 27 other tr		Barbara Horano 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☒ Donation 5 ➡ Other (5	3 □Removal from	20b. Place	of Disposition				n MD 210 c. Location - City or	
Maryland d 2 should be file th and Mental Hy to emarked oth treumatic event	Tof	Calvin Hooper		15	b. Mailing Ad			Cecilia Al Route Number, C	Heard ity or Town, State, 2	lip Code)
e filed v al Hygie other t	Be Co	12 17. Father's Name (First, Middle,	(Last)		carper		. Mother's Name	(First, Middle, Mai	ome improv iden Sumame)	rements
21215-0036 d within 72 hours af giene. or then "natural; or , the Medical Erani	Completed	(Specify only higher Elementary/Secondary (0-12)) (1-4or 5+)	(Give kind life. DO N	Usual Occupation of work done during OT use retired)	n ng most of worki	ng	b. Kind of Business/	,
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "natural", or iteme 23a or 28a-1 ehow eumatic event, the Medical Exprimentments confided at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	rried Armed F	2 No		Decedent of Hispa , specify Cuban, M es 2 X No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
3a or 26	i Director	10e. Street and Number 2429 Laurel Br	rook Road		10	f. Zip Code	21047	10g.	. Citizen of What Co USA	untry?
e Maryl	ctor	MD Har	ford	Fa	llston					1 ☐ Yes 2 ☐ No
D D		Usual Residence of Decedent 10a. State 10b. County	/		wn or Location	1			, , , , , , , , , , , , , , , , , , , ,	10d. Inside City Limits
Funera Directo		5. Social Security Number 218–09–5490	6. Sex 11X2 M 2□ F	7. Age (In yrs. last t			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Nov 7, 1	9. Birt Co 917 Mar	nplace (State or Foreign untry) yland
) Exam	iner	4a. Facility Name (If not institutio 2429 Laurel E			40.	City, Town, or Lo Fallstor			4c. County of Deat Harford	1
Physi /Med		Thomas R. Gil						June 21	2007	3:30 AM M
		1. Decedent's Name (First, Midd	lle, Last)		00/1///	cate of De		Reg. 2. Date of Death Month	Day Year	3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per dvr 8869 7-2-07 vt. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registre Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 2007 06 James Michael Garippa, Jr. 28 12:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/24/1924 9. Birthplace (State or Foreign Country) New York Funeral 7. Age (In yrs. last birthday) Days 1 x M 2 ☐ F 83 Months Hours Min. Director 104-16-0179 Usual Residence of Decedent 10a State 10c, City, Town or Location 10d. Inside City Limits 10b County 7 is marked other than "netural", or Items 23e or 28e-f show traumatic event, I're Medical Examination must be notified at 1 √yes 2 No Director Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 1169 Simsbury Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: 1943-45 þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Textile Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmella Pellitieri James Peter Garippa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Michael Garippa III / Son 10602 Vista Road, Columbia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or oth cometery, crematory or other place)
Lakemont Memorial
Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify) 07/02/2007 Davidsonville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Tues 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** INFARCTION /Medical Examiner OLON ORSTRUCTION 1 Werk Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit 04 COLON ASENDMA that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 ğ Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed ARZERY CORONARY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has TOBACCO 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 2 1 ☐ Yes 2 No 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural death. 1 TYes 2 TNo 2 Accident Director: in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel I ical 29a, Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mangler stated. Fo the 29d. Date signed (Month, Day, Year) 286. Signature and title of certifier 6-29-2007)-35235 HX Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL PRWY ANNAPOLIS, MS MATTESON E 7001 DAUTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** June 18, Catherine M. Gionis 2007 12:50 KM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care Montgomery Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2XF 235-24-6622 Director 85 1922 West Virginia June 1, Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "naturel", or Items 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Montgomery Potomac Director 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code 9201 Harrington Drive 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 🏋 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tony Zanotti Marie Copsahilis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other treum once. Chrissellene G. Petropourlos/Niece 9201 Harrington Drive, Potomac, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 6/21/07 Rockville, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature Juneral Sevice License 3821 14th Street, NW, Washington, DC Part . Enter the diseashock, or heart fail to Approximate Interval Between Onset and Death , or complications that caused the List only one cause on each line. Texth. So not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (First disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Renown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 1 Yes 2 XNo or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lled in by 4 Homicide 🕦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 12

02

Pro jac-

Tilly Mys

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DHMH 17 Rev 1/2001

21 162 Chengran

32. A signature

D0054566

They Sir version right work

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician 3:15 P.M 28, 2007 Jessie June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 21 F Months Days Hours 218-44-9677 101 Director Aug. 17, 1905 | Maryland Usual Residence of Decedent 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must vonce. 21202 U.S.A. 314 Albemarle Funeral Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas J. D'Alesandro Sr. Antoinette Foppiano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Albemarle Street Balto. Maryland 21202 Carmine J. Granese Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 7-2-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Joseph N. Zannino Jr. Funeral Home 21224 263 S. Conkling St. Balto Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licenses 23a. Pant. Enter the dise shock, or heart failure. Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestive heart failer Physician Stage End /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 28, 2007 30. Name and address of person who completed cause death (Item 23a) (Type, Print) le St Balto and Zczok N-Cha 6201 G BMC Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

JUL 02 2007

Box 68760,

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

			Please	Type or Prin				Ensure Allealth and M			•		
			For State Registrar		-	Certificat				Reg. No	1111	21	151
	Physici /Medic		1. Decedent's Name (First, Middle, La Samuel Larry		ns				2. Date of De Month May	eath Da 27		3. Time o	
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or	Location of Death			County of Death		
			Prince Georges Co				verly	If Under 24 Hrs.	9 Data of Dia		ince Geo		
	Funeral Director		5. Social Security Number 6. S 577-56-2226 Usual Residence of Decedent	M 2□F	e (In yrs. last birtho	Months		Hours Min.	8. Date of Bir (Month, Da 09/20/	y, Year) 1943		place (State intry) ington	
	aryland show d at	<u>-</u>	10a. State 10b. County		10c. City, Town o						· · · · · · · · · · · · · · · · · · ·	10d. Inside C	City Limits
	the M 28a-f notifie	Funeral Director	Maryland Prince G	Georges	Clinton	10f. Zip	Code			10g. Cit	izen of What Cou		-12,110
	3a or st be	E D	9003 Canberra Dri	ive		20	735			USA			
	deatl ms 2	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece	dent of H	ispanic Origin? (Sp	ecify Yes or No		14. Race - Amer		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fnjury or other traumatic event, the Medical Eximiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ I If Yes, Give Year or Dates:	1963	1 ☐ Yes		n', Mexican, Puèrto Specify:	HICAN, etc.)		Specify: B1a		
21215-0036	72 hoi 'natura dical E	Completed by	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. D	ecedent's Usu Give kind of wo	al Occup	ation during most of work l)	ing	16b. K	ind of Business/l	ndustry	
121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5	o+)	ife. DO NOT u: iness (F1	ectroni	20	
d 2	2 should be filed w n and Mental Hygie is marked other ti raumatic event, th	BeCc	17. Father's Name (First, Middle, Last)	Dus	THE35	JWITE	18. Mother's Name	e (First, Middle,			-5	
Maryland	Menta Menta arked atic ev	To B	Dennis Cason, Sr.	•				Georgia	Greenl	eaf			
/Jan	2 sho		19a. Informant's Name/Relationship (and Number or Rui				•	
	Health Health tem 27 i		Marion H. Harris/ 20a. Method of Disposition	Sister	20b. Place of D	isposition (Nar	me of		ad, Col		a, Mary		1044
Baltimore,	Pages nent of I ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Chelter	crematory or c inam Ve	ther place tera	ns lune	4 2007		ltenham,		and
altir	permit. Page Department o Important: If any Injury or once,		21. Signature of Funeral Service Lice		Cemeter		nd Addres	ss of Facility Ve					anu
<u>0</u>	an In Sec		Fernest	The Col	vin	_15381	Roos	sevelt Bl	vd., C1	earv	vater, F	և 3376	0
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	the death. Do no ne.	t enter the mod	de of dyin	g, such as cardiac	or respiratory a	ırrest,		Approxima Interval Be Onset and 1 week	etween Death
1	/Medical		disease or condition resulting in death)	•	a consequence of)						-	1 weer	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D.	enal Fail a consequence of)							10 day	7S
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	,		 					
760,	te be ey /sician e buria	<u>es</u>		_d	2 001100 44001100 01)								
687	rtificat ng phy as th	Medi	IF FEMALE:										
P.O. Box	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the totals.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic po 5 □ Other (sp		,			23d. Date of deli Month	,	Year
	uires that signed b	d by Pi	Part II. Other significant conditions of Diabetes Mellitu	_	ut not resulting in the		ause give	en in Part I.			use contribute to		
Records,	e law requir has been si je 2 should b	Completed by	Respiratory Fail	ure					24a. Was		24b. Were au	topsy findings	available
E		Com	Coronary Artery	Disease					perfo 1□ Yes	ormed? 2 No	death?	•	
or Vital	Physician: this certification director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	_26. Place of Deat					
Ö		7.	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outp		28c. Injur Worl	4 LI Nuising nu	ome 5 Resi 28d. Describe	_	6 ☐Other (Spec ry occurred	rify)	
ion	Attending For death. ector: After by the funer.	atior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Inju	iry M		k? Yes 2 □ No		·			
Division	or Attendafter death. Director: /	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of mi	ury - At home, farm c. (Specify)	n, street, factor	y, office		28f. Location (City or To	Street ai	nd Number or Ru e)	ral Route Nur	nber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 2 Medi al Example 1	nysician: To the best miner: On the basis o	f examination and/	death occurred or investigation	l at the tir	ne, date and place, pinion, death occur	and due to the	cause(s	a) and manner as d place, and due	stated. to the cause((s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifien	and manner sta	MVY	29	c. Licens	e number		29d. Da	ite signed (Month	, Day, Year)	
	FSFO			lly		D	1627	3 MD		May	28, 200	7	
	X		30. Name and address of person who Revathy Murthy,				r117	Marulan	1				
	Sta		31. Date filed (Month, Day, Year)	3 Registr	ar's Signature	berter	тту,	rial y Lail	4				
	Registi	ar	JUL 0 2 20	THE REAL PROPERTY.	- ~ /	-							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician Month June 20, 1:05 AM M Sewilla Holmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F 83 Oct 11, Director 444-24-7711 0klahoma 1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at MD 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 N. Caroline Street 21213 USA by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black Specify. 3 ☐ Widowed 4 ☐ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumes? College (1-4or 5+) unk contract worker roads & highways 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Vernetta McRae/Dept on Aging 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) in state 21. Signature of Edneral Service Licensee Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore, MĎ Part1. Inter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Faste INKIYUUN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a noneque roa off Examine as the burial-transi Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform After this certificate 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) anism 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 83 K. Hamsin 31. Date filed (Month, Day, Year) State Registrar

6/20

5W16

			For State Registrar	State of M				t of H	ealth a	and Me	ental Hy	giene	19.7	211	60
12	Physici	an	1. Decedent Name (First, Middle	e, Last)	00					1	2. Date of Dea Month		Year	3. Time of	
15	/Medic Examin	al	4a. Facility Name (If not institution	n, give street and number	9		4b. City,	Town, or	Location of	of Death	06	4c. Co	2001 unty of Death		3 /1
	LAdilli	-	4208 Barringt						timor						
	Funeral Director		5. Social Security Number 220–38–5733	6. Sex 7. Ag	ge (In yrs. 64	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Day (ay 19,	1943	9. Birth Cou Penn	place (State d intry) sylvan	or Foreign ia
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d, Inside C	ity Limits
	a-f eh	ctor	MD			Ва	ltimo	re						¹ X Yes	2 🗆 No
	vith thu	Dire	10e. Street and Number				10f. Zip					10g. Citizen	of What Cou	intry?	
	eath v	erai	4208 Barringto	n Koad 12. Was Decedent	Ever in U	S. 13.	Was Deced		1229	igin? (Spec	fv Yes or No-	US	A Race - Amer	ican Indian.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel', or Items 23e or 28s-f show any figury or other traumatic event, Ite Madical Expedient must be incilled at page.	by Funeral Director	1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Forces	?		If Yes, spec		Specify:		ify Yes or No- ican, etc.)		Black, White ecity: Wh:	, etc.	
21215-0036	hin 72 hou e. en "nature Modical E	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or	5+)	(Give	dent's Usua kind of woi DO NOT us	rk done a	lurina mos	st of working	7	16b. Kind	of Business/I	ndustry	unk
21	ygiene ygiene her the		12	1		sal	esper	son	40.14.1		(7)	44:1. 0			
Maryland	id be fi ental H ked otl ic ever	To Be	17. Father's Name (First, Middle, Erwin Carl H								First, Middle, Anne M				
lary	and M and M ie mer	-	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Z	ip Code)	
	and sealth		Patricia Graves	s/sister	205.5				Aven	ue Ba.	ltimore		21228		
Baltimore,	Pages I		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☒ Donation 5 □ Other (5	pecify)	1 /	Place of Dispo emetery, cre	natory or o	ther place	e) 	- Da	19	20c. Locati	ion - City or 1	own, State	
Ball	permit. Depart Import any in		21. Signature (Funeral Septice)	S. Waje, Dir	ector	-	ate A		-		655 W.	Balti	more :	Street	
1760,	Physician and Medical Examiner transit the private transit tra	cai Examiner	23a. Part 1. Enter the disease, of shock, or hearf tailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a conseq	STAT uence of):					CAN C			Approximatinterval Bet Onset and	beath,
P.O. Box 687	The law requires that the death certificate are been signed by the attending physpage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Feta t time of d	I death 3 E	Ectopic pri	ecity)					Date of deliment	Day	Year
	uires the signer		Part II. Other significant condition	ons contributing to death t	out not res	ulting in the u	nderlying ca	ause give	n in Part I	l.	236. Did to			the cause of cobably 4 🗀	
Vital Records,	The law requir ate has been si page 2 should i	Completed									24a. Was autop perfor		4b. Were aut prior to c death? 1 ☐ Yes	opsy findings ompletion of o	available ause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?							e of Death (Check only o		siste		me
	Physic rthis ral dir	<u>۲</u>	1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatier		8c. Injury	4 🗆 NU	1	e 5 🗌 Resid		Other (Spec	ify)	
on	nding F ath. r: After e funer.	ation	1 Natural 5 Pendir 2 Accident investi	g (Month, Da	y Year)	Injury	м	Work	(? Yes 2 □			,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division of	To the Hospitel or Attending Physician: The law within 24 buours after death. With Ennarel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	28e. Place of In building, e			eet, factory	, office		28	of. Location (S City or Tow		umber or Ru	ral Route Nurr	nber,
	To the Hospitel within 24 hours a To the Funaral Completely filled	edical C	29a. Certifier (Check only one)	ig Physician: To the best Examiner: On the basis of and manner st	t examina	wledge, deat tion and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	nd place, an	d due to the d	cause(s) and date and pla	d manner as	stated. to the cause(s	s)
	To the within To the comple	Me	29b. Signature and title of certifie				29c	License	number			4	gned (Month		
)			· Ew	Cale L	D				135			6/2	10/2	007	
	0.		30. Name and address of person E. W. COLE 31. Date filed (Month, Day, Year)	STAGNE	5 6			NA	UE	BA	ZTIMO	ORE	MD	2122	9
	Sta Registr	12.		2007 Kenn	, J	fre	W								

	1	For State Registrar		State	of Maryla	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	ınd M	lental Hyg	giene	07)	51
Physicia	n	1. Decedent's Name (F		•							2. Date of Dea Month	ath Day	Year	3. Time of D	
/Medica Examine		la. Facility Name (If no			umber)		4b. City, To	own, or	Location o	f Death	June 2		ty of Death	2:35 A	MM
	in I	Asbury M		t			Gaith					Mont	gomer	У	
Funeral Director		5. Social Security Num 394-30-090		Sex 1□M 2√2 F	7. Age (In yrs	7 Yrs.	ff Under 1 Months	Year Days	If Under a	Min.	8. Date of Birth (Month, Day Sept 6,	r, Year)	Coi	nplace (State or untry) yland	Foreign
and	-	Jsual Residence of De 10a. State 10	ocedent Ob. County		10c. C	City, Town or Lo	cation							10d. Inside City	Limits
Mary	101	MD	Montgom	nery		Gaithe		ζ						1 🗆 Yes	
a or 288	5	10e. Street and Number		iue			10f. Zip C	code 208	77			10g. Citizen o	f What Coi	untry?	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "natural", or Itema 23a or 28a-f show aumatic event, the Maxical Examinar must be notified at	by rur	11. Marital Status 1 □ Never Married 3 🏋 Widowed 4 □		Armed F	2 XNo ive	,	Was Decede 1 Yes, specifi 1 Yes 2	y Cubar	spanic Origin, Mexican	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)	В	ace - Amer lack, White		
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 le marked other then "natural", or traumatic event, the Maylical Exam T. D.D. Compiled the	Completed	(Specify (Specify Elementary/Secondar)	Decedent's E only highest gra ary (0-12)	ade completed College) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d	urina most	of work	_{ng} unk	16b. Kind of	Business/I	ndustry	unk
'	lo ne C	John Lee)							e (First, Middle,				
and Manda		19a. Informant's Name	/Relationship (Туре, Print)		19b. Mailir	g Address (Street a			A Route Numbe			ip Code)	
Baltimore, Marylari permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic av pice.	-	John K. Iş 20a. Method of Disposi 1 □ Burial 2 □ C 4 ໘Donation 5 [ition Fremation 3	Removal from		1020(Place of Dispo cemetery, crer	sition (Name	of			thesda,	MD 20 20c. Location		Town, State	
Baltir permit. P Departme Importan any injury ance.	-	21. Signature of Europe			irecto	r St	Name and	Addres natc	s of Facility	ard	655 W.	Baltin	nore	Street	
ate be executed Wedical Wysician and the burial-transit Wedical Examiner	Cyalline	23a. Part I Enter the oshock or heart fe Immediate Cause (Fin disease or condition resulting in death) Sequentially list condit fany, leading to immediate. (Disease or injultational initiated events resulting in death)	ions, idiate ng ry	b. Due to		quence of):		of dying	, such as	cardiac o			4	Approximate Interval Betwonset and D	eath
death certif	iyaiciai mid	F FEMALE: 23b. Was decedent pre in the past 12 mpl 1 Yes 2 No 9 Unknown	hths?	1 Live	utcome of pregr birth 2 Pet mant at time of nown	aldeath 3	Ectopic preg Other (spec						23d. Date of delivery Month Day Year		əar
The law requires that has been signe page 2 should be completed by	o ne completed by	Part II. Other significant Recent To Concern Special S	sten	Hospital.	ecite Pen	Lesta	ings	tes.	26. Place	of Death		an 24b	3 Pro . Were aut prior to codeath? 1 Yes		nknown
Sing I	5 2	2 Accident 3 Suicide 6	Pending Investigation Could not be	e 280 Bloo	of fnjury oth, Day Year) e of Injury - At I	28b. Time of Infury	М			10	28d. Describe h	ow intury occi	urred		Θ <i>r</i> ,
pital or purs after eral Direction in Experimental Direction in Experi	5	4 ☐ Homicide	,	buito	ling, etc. (Spec	ify)			I regulativita in		City or Tow	n, State)			
To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		one)	Medical Exar	niner: On the t	pasis of examin nner stated.	ation and/or inv	estigation, in	n my op	inion, deat	h occurr	and dea to the dead at the time, o	fate and place	e, and due	to the cause(s)	
Towin Too	- "	29b. Signature and title		Ecisi	Lhau	and:			A//	>		lectic			
		10. Name and address						fir	CUS	586 S. 5	LAUE, L	WLIE	084	1	
State Registrar		31. Date fifed (Month, E	0 2 200	7	Registrar's Sign	dead	BI								

1 - For State Registrar

Reg.	No.	

Physician
/Medical
Examiner

Funeral Director

ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

lore, Maryland 21215-0036

Baltir	permit. Pa	Important: any injury	
	Phy /M Exa	rsicia ledica amine	2
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
	2	0	
-/	/		

	_														
ysici Medic		Decedent's Name (First, Middle, Last) ROSALIE JOHNSON		2. Date of Death Month JUNE 2	27 2007	3. Time of Death 12:05p M									
amin		4a. Facility Name (If not institution, give street and number) Chester River Manor	4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	h									
eral		5. Social Security Number 217-24-1365 6. Sex 1 M 2 AF 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,)	(ear) Coi	nplace (State or Foreign untry)									
fied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MARVIAND KENT	HESTERTOWA	/ /		10d. Inside City Limits 1 ☐ Yes 2 📉 No									
noti	Director	10e. Styleet and Number	10f. Zip Code		g. Citizen of What Co	untry?									
st be		200 MORGNEC ROAD	21621	5	1150	1									
, mus	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer										
mine	F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give	If Yes, specify Cuban, Mexican, Puèrto 1 ☐ Yes 2 【 No Specify:	Hican, etc.)	Black, White										
Exar	d by	3 Ma Widowed 4 □ Divorced Year or Dates:	TEL Tes Zag No Specify.		Specify: B	LACK									
dical	etec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business/	ndustry									
ine iwe	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OMEMAKER		OWN F	tomE									
ent, l	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M.											
tic ev	To B	WILLIE GOME	R IDA		PAI	RKER									
anii		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rur	al Route Number,	City or Town, State, 2	(ip Code)									
any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Hemoval from State	matory or other place)	Date 2	Dc. Location - City or										
njury		4 □ Conation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2. HILL CEME 17-12. Name and Address of Facility	30110	TLEN YOU	RNIE, MD									
any I		baccuelya o Co Kora o	JOSEPH H.	KOUNG	JK, FUN	ERAL HOME									
		23a. A 1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dving, such as cardiac		BALTO. M	Approximate									
		slock, or hent failure. List only one cause on each line. Interval Between Onset and Death													
ian ical		disease or condition resulting in death) a. Due to (or as a consequence of):													
ner		Sequentially list conditions b. Callulates													
	ē	Sequentially list conditions b.													
ansır	Examiner	cause (Disease or injury that initiated events c. Carvical Stanosis													
ומורו															
Tor use as the burial-transit	an/Medical	d													
e da	Med	IF FEMALE:													
5		23b. Was decedent pregnant in the past 12 months? 1□Live birth 2 □ Fetal death 3			23d. Date of deli Month	very Day Year									
	Physici	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)			,									
;	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?									
	d by	Dinbates		1 ☐ Yes	: 2₽No 3□Pr	obably 4 Unknown									
i	Completed	Ronal Institu	004	24a. Was an	24b. Were au	topsy findings available									
0	duc	1.00		autopsy perform	ed? prior to death?	completion of cause of									
	a	25. Was case referred to medical	26 Place of Deat	1 Yes 2 h (Check only one		2□ No									
	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	044		ice 6 Other (Spe	cify)									
5	L H	27. Manner of Death 1 Natural 5 Dending (Month, Day Year) Injury 28b. Time Injury		28d. Describe how											
	atio	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No												
2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,									
completely illeu in by the tuneral director, page ∠ sitoulu be detached	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in any manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)									
d E O	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	h, Day, Year)									
,		1) 58824 6/29/0													
		30. Name and a dress of person who completed cause of death (Item 23a) (Type			10/1/	1									
			h Main St. Gale	ena, MD.	21635										
Sta	te	31. Date filed (Month, Day, Year) 32. Signature													
gistr	ar	1111 0 2 2007 Beauty St A	porter												

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 29, 2007 Month Physician P^{M} Thomas Jones, 7:30 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs 86 Director 214-14-9436 30,1921 Maryland April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Marylan 1 ☐ Yes 2 XNo notified Completed by Funeral Director Baltimore Rosedale Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n U.S.A. rai", or items 23a Examiner must I 21237 8313 Karl Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 □ Divorced Year or Dates: White 29,2007 er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th. Grade Truck Driver Dairy is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Jones, Sr. Margaret Estelle ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Barbato/Daughter 8313 Karl Avenue Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Department Important: It any Injury o 4 ☐ Donation = 5 ☐ Other (Specify) Gardens of Faith Cem. 07/03/2007 Baltimore MD 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licens 6415 Belair Road Baltimore MD 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Its only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOMY TAGE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical address.

To the Funeral Director: After this a completely filled in by the funeral director. Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANCY VILLY RD acom HAM TARIQ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 2 2007 Registrar

			State of Mary		rtment of He tificate of De		_		
N			1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)		incate of D	Cutii	2. Date of Death		3. Time of Death
	Physicia /Medic		Nellie Day Keimig				June 27,	, 2007	12:20 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County of Deat	
, a i de			Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (//	In yrs. last birthday)	Timo If Under 1 Year	N1UM If Under 24 Hrs.	8. Date of Birth	9. Birt	timore hplace (State or Foreign
	Funeral Director			33 Yrs.	Months Days	Hours Min.	Mar. 18	1924 Mary	y land
	and w		Usual Residence of Decedent 10a. State 10b. County 10	0c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla f sho	to	Md. Baltimore		Par	kville			1 ∐Yes 2X No
	or 28a)irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	ath wi	ral	2926 Chenoak Avenue			21234		USA	vices Indias
_	ter de items iner m	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No		Was Decedent of Hisp f Yes, specify Cuban,		ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	ral", or	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1	I∐Yes 2∐XNo	Specify:		Specify:	White
ה ה	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupati kind of work done dui DO NOT use retired)	on ring most of work	ing	16b. Kind of Business/	Industry
7	I withir liene. r than the Me	omp	Elementary/Secondary (0-12) College (1-4or 5+)	mc. c	Teach			Educa	tion
0	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)		1	8. Mother's Nam	e (First, Middle, N		
<u> </u>	should be filed within 72 hours after death with the Maryland not Mental Hyglene. In the Wested other than "hatural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	卢	John Ingle	405 14-15-	- Add (044	d North an an Door	Rosalie	City or Town, State, 2	
2	nd 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationship (Type. Print) Mrs. Wilma L. Short/Daughter		Church Ro			Maryland 2	
Ę,	s 1 ar		20a. Method of Disposition		sition (Name of natory or other place)			20c. Location - City or	
Dallillo	Page ment c ant: If		1 💆 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (<i>Specify</i>)	Parkwood	Cemetery	6/30/		altimore, M	
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Machael Number 1. Signature of Funeral Service Licensee		Name and Address 1050 York			n Funeral aryland 212	
ı			23a. Part1. Enter the disease, or omplications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying,	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. UROSEPS						Onder and Double
	Examiner		Due to (or as a c	onsequence of):					
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):					
	ecute and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c	consequence of):					
0/00,	cate be executed physician and the burial-transit	dical E	300.00/07.00.00	ondoquonos ory.					
0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		u.						
X O O	ding Physician: The law requires that the death certifith. h. fatter this certificate has been signed by the attending fatteral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf 1 □ Live birth 2.	☐Fetal death 3☐	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the de y the a	ysic	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	ne or death 5	Other (specify)				
λŲ.	s that med by e deta	by Ph	Part II. Other significant conditions contributing to death but n	not resulting in the ur	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
cords,	equire sen siç ould b						1 □ Ye	es 2 No 3 Pi	robably 4 KUnknown
į L	e law has bu je 2 sh	Completed					24a. Was ar autops	v prior to	utopsy findings available completion of cause of
Z.	in: Th ificate or, pag		25. Was case referred to medical			26 Place of Dog	pertörn 1∐ Yes 2 th (Check only one		2 □ No
	Physician: r this certificaral director, I	То Ве	examiner? 1 ☐ Yes 2 ▼ No	2 ER/Outpatien	Othor			nce 6 NOther (Spe	cify) HOSPICE
10 U	ing Ph		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work?		28d. Describe ho	w injury occurred	
VISION	Attending r death. ector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury	- At home, farm, stre		es 2 □No	28f. Location (St	reet and Number or R	ural Route Number,
2	tal or A s after al Dire ed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town	ı, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of real manner: On the basis of evand manner stated	xamination and/or in	h occurred at the time vestigation, in my opi	e, date and place nion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and du	s stated. e to the cause(s)
	То th within То th сощр	Me	29b. Signature and title of certifier		29c. License	_		9d. Date signed (Mont	
					1-	1372		6/27	107
	7		30. Name and address of person who completed cause of deat DR. TARIO MAHMOOD 2300 DUI		Print) LEY RD. T	TMONTTM	MD 2104	,	
ľ	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's		and IND. I	THUNTUH	TID 210	<i>,</i> ,	
	Registr			B 2	# AR				

DHMH 17 Rev 1/2001

12:20 р.ш.

JUNE 2/, 200/

NELLIE KEIMIG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:30 8 M 2007 1185 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore -ity e Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 243-44-5916 5/20/1919 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Baltimore MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6415 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 7 is marked other than "natural", or Items traumatic event, the Medical Examiner m 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) House Keeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number, Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Butto. Co. permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra ma 2120 Augustine 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Fred Felow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ≥ 2No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Ves 2 □ No 24a. Was an autopsy performed? 2 □ No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b, Signature and title of certifie D45000

DHMH 17 Rev 1/2001

State

Registrar

School of Medicine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

02

Crain

Johns

3 Registrar's Signature

Dale Clerence La	~	ston 1- For State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rep. No.												
Physicia		Registrar 1. Decedent's Name (First, N	Middle,L	ast)		- Crimoato				2	. Date of D	Reg. N eath			3. Time of Death
Medical Exami		Dale C. Lan									Month June 11	. 200	y Year 7		0910 hrs
(4a. Facility Name (if not inst			mber)		4b. C	ity, Town, or L	ocation of	Death			4c. County of	Death	
		10 Seward Avenue	Э				В	rooklyn					Anne Arur	ndel	
Funeral		5. Social Security Number	6.	Sex	7. Age (In yr	s. last birthday)	_	Under 1 Year	If Under		8. Date of	Birth(M			place (State or
Director		218-62-0770	1	X _M ₂ _F		52	Yrs. N	onths Days	Hours	Min.	Nov	5,	1954	oreign Cour	ntrMaryland
	ŀ	Usual Residence of Decede	nt					1							
any		10a. State 10b. Cou			10c. C	city, Town or Lo	cation							- 1	10d. Inside City Limits
and show	5	MD Ann	ie Ai	cunde1		Brook1	.yn								1 Yes 2 X No
Aaryla 28a-f	Director	10e. Street and Number					10	f. Zip Code				10g. (Citizen of What		ry?
eath with the Maryland items 23a or 28a-f show ust he notified at once.	اة	10 Seward A	ven	1e			21225						USA	١.	
ms 2.	uneral	11. Marital Status	¬	A	cedent Ever in	U.S. 13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican,								Americ etc.	an Indian, Black,
death or ite	Fun	1 X Never Married 2	Marri	1 Yes	2 X N	40				· dorto i					
ral",	à	3 Widowed 4		ed If Yes, Give Yea or Dates:		1		2 X No			Specify: W				
hours		15. Decedent's Education					Isual Occupation from the state of state of the state of			161	o. Kind of Busi	ness/In	dustry		
36 in 72 in an "	E E	Elementary/Secondary (0)-12)	College (1	I-4 or 5+)										
5-0036 ited within 77 Hygiene. I other than	ompleted	17. Father's Name (First, Mi	iddle I a	0		01	led I1	s Name (First, Middl	e. Maid					
15.	Be C			The Langston Betty Jane Young							,				
2121 ould be fi Mental marked	.0	19a. Informant's Name/Rela			011	19b. Ma	iling Ad						City or Town,	State,	Zip Code)
MD d 2 sho lth and n 27 is		Betty Brose	ker	sister		803	1 Be	osley C	Court	G1e	n Bur	nie	, MD 2	106	1
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It and the stand that and the stand of the stand of the stand of the stand on the Natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition				b. Place of Dis	position	(Name of cerr	netery,		Date		c. Location - C	ity or 1	own, State
JOF ages ages in tofil		1 Burial 2 Crem			om State	crematory o	otner t	nace)	ĺ						
Baltimore, permit. Pages 1 a Department of He Important: If ite	1	4 X Donation 5 Oth 21. Si nature of Funera Se				2	2. Name	and Address	of Facility	1	(Baltimo		C 4: 4:
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important; If tien 27 is in injury or other traumatic		Ronal	dS.	Wade,	Direct			e Anato imore,		oard 2120:		W . 1	saltimo	re	Street
Physician		23a. Part I. Enter the diseas	e, or co	inplications that o	aused the de	eath. Do not ent	er the m	ode of dying,	such as ca	ardiac or	respiratory	arrest,	shock, or hear	t	Approximate Interval Between Onset and
/Medical	1. 3	failure. List only one of Immediate Cause (Final dis		a. Narcotic In	toxication										Death
Examiner		or condition resulting in dea		Due to (or as a											
	L	Sequentially list conditions,		b		6								_	
	ine	if any, leading to immediate cause. Enter Underlying C	BUSer	Due to (or as a	a consequenc	ce of):									
=	Examiner	(Disease or injury that initial events resulting in death)	g in death) Last Due to (or as a consequence of):												
O, e be executed /sician and burial - transit			d												
O, e be exe ysician burial -	edical	UNPENDED		AMENDED											
Sox 6876C leath certificate e attending phys for use as the bh	/Me	IF FEMALE: 23b. Was decedent pregnan	t in the		outcome of p	regnancy			Fatasia				23d, Date of d		Voor
68 certif	ian	past 12 months?		1 Live t	oirth nant at time o	of death 5	Fetal c	leath 3 ((Specify)	Ectopic	pregnan	icy	Į.	Month	U	ay Year
Box e death c the atten	Physician/M	1 Yes 2 No 9	Unkno		own	٥	Other	(Opecity)							
O. B at the d d by the		Part II. Other significant c	ondition	s contributing t	o death but n	ot resulting in t	ne unde	rlying cause g	iven in Pa	rt I.	23e. D	id tobac	co use contrib	ute to t	he cause of death?
s, P.O. ires that the signed by t	d by										1	Yes 2	No 3	Prob	ably 4 🗹 Unknown
ords, w requir ts been s should	lete										24a. W	as an utopsy			opsy findings available empletion of cause of
Recol The law icate has	Completed										pe	erforme es 2	d? de	ath? ✓ Ye	_
ital Reckinn: The scertificate		25. Was case referred to m	edical	Τ-				26.Place	of Death	(Check o					
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should l	o Be	examiner? 1 ✓ Yes 2 No	,	Hospital: 1	Inpatient 2	ER/Outpat	ent 3	DOA	Other ₄	Nursing	Home 5	Res	sidence 6 🗸	Other:	Scene
of hing Ph	y 28c. Injur	y at Work		28d. Descri Jnknown		injury occurre	d								
on tendin eath.	ţi	1 Natural 5	Pendin	9 1	n, Day,Year) D: 2007	FOUND: 0850 hrs		1 Y	'es 2 ✓	No C	JIKIIOWI				
Division tal or Attendi rs after death.	ific		Could r	28e Plac		At home, farm,	street, fa	actory, office b	uilding, et	c. :		n (Streen, State		or Rur	al Route Number, City
Division 1 Hospital or Attend 24 hours after death. 5 Funeral Director: etely filled in by the f	Certification:	4 Homicide	determi	ned (Specify)	Single F	amily					0 Seward	Aveni	ue , Brooklyn	, MD	
e Hos 24 h e Fun etely		(Gridon drill)		sician: To the be											
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 bars after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	4		ner: On the basis and manner:		on and/or invest	igation,			curred at	ute time, d				
	Σ	29b. Signature and title of o	certifier	,1 ~				29c. License O.C.N					d. Date signed		ui, Uay, Year)
		Certa	u	1-01		Lel C	_	0.0.1	VILE.			٦	une 12, 20	01	
		30. Name and address of p					n Str	eet, Baltimo	ore MD	21201					
		Carol Allan, MD		stant Medical			الات الا	Date Date HITC	JIE, MD	21201	_				
S	tate	31. Date filed (Month, Day,	rear)	007	egistrar's Sig	H An	ME								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lyndal Loudermilk 10:15 P June 25, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3141 Yorkway Baltimore Co. Dundalk If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours t□M 2XF Director 216-54-1809 3,1951 West Virginia Jan. Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygelne. International files as a second internation of items 23a or 28a-f show Important: If Item 7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Dundalk Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 3141 Yorkway Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Edna Taylor Kermit Bruce Fortney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 3141 Yorkway Thelma M. Worth (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6/30/2007 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appendix Appe Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancer una years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical ası for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2□No 1☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN D53590 JUNE 26, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 40 MEM DY MD ROOM 609 BROADWAY

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

02

2007

32 Registrar's Signature

21205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 27, Mary Elizabeth Moebuis 2007 1:55 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Divine Care Hospice Harford Abingdon 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🗙 F 214-14-8078 11-24-1920 86 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Stickton Rd 21085 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Farley Nellie Molen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa, MD 21085 Sueanne Arnew (Daughter) 1325 Stockton Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-02-2007 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the at Id be detached for been si within 24 hours after de To the Funerel Directo completely filled in by th

Physician

/Medical

Examiner

Director

Funeral

á

Completed

Funeral

Director

r then "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at

Depertment of Health and Mental Hygic Important: If Item 27 is marked other eny injury or other treumatic event, IL once.

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	disease or condition resulting in death)	a. No currence Due to (or as a consequence of):	y wwn	enon		2 years			
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year			
ed by Pr	Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use							
Complet				24a. Was an autopsy performed:	prior to death?	utopsy findings available completion of cause of			
Be	25. Was case referred to medical examiner?			th (Check only one)					
ပ္	1 ☐ Yes 25 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Cther: 4 ☐ Nursing H	lome 5 Residence	6 ☐Other (Spe	icify)			
ation:	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	jury occurred				
Sertific	3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street City or Town, Sta		ural Route Number,			
Medicai Certification:	29a. Certifier (Check only one) 1/5 Certifying Ph 2 Medical Exam	nysicien: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the fime, date and place gation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner a and place, and due	s stated. e to the cause(s)			
ž	29b. Signature and title of certifier	41 D	29c. License number 2005660		Date signed (Mont				
		/	100000	, 00	00/-	~~/			
		completed cause of death (Item 23a) (Type, Print GEZO, #205 66	02 S. A7UDO	DRJ.	3EL AZ	21214			
	D4 Date Hard (March Day Vand)	00 mm). 1 0:							

Registrar DHMH 17 Rev 1/2001

State

i O

31. Date filed (Month, Day, Year)

32. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #12 Per Blace of Maryland 7 Department of Health and Mental Hygiene 1 = State Registrar6-15-07 Amend#20c.PerFHPCCcr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 12 **Physician** 2007 6:03 A M DAVID L. MOORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES LAPLATA 9290 PENNS HILL RD. ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 03/22/ 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs, last birthday) **Funeral** 235-80-0057 Months Days Hours WEST VIRGINIA 12 M 2□ F Yrs. 57 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State r 28a-f show Worle LAPLATA 1 Yes 2 No MD CHARLES Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? rthan "neturel", or iteme 23a or the Muzical Examiner must be a U.S.A. 20646 9290 PENNS HILL RD. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1. XXes - 25-No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 ☐ Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Coflege (1-4or 5+) Elementary/Secondary (0-12) FTC GRAPHIC DESIGNER other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဥ GRETCHEN SCARBRO DAVE L. MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9290 PENNS HILL RD. LAPLATA, MD 20646 19a. Informant's Name/Relationship (Type, Print) MARY A. MOORE/WIFE Heelth Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Slate ALEXANDRIA VA. Department of Important: If It eny injury or o 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State ALEXANDR 6/14/07 ALEXANDRIA, VA-STRICKLAND FUNERAL SERVICES METROPOLITAN CREM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MDCAMP SPRINGS, 6500 ALLENTOWN RD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Division of Vital Records, ۵ 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2X) No 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturaf 5 Pending death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours Funerel 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 vocal allumin D44885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 5100 AUTH WAY

32. Registrar's Sign

MD

ROSCOE ADAMS,

31. Date filed (Month, Day, Year)
JUN 1 5 2007

MD 20746

MARLOW HEIGHTS,

			State of Maryland / Department of He 1- State Amend PI, line b perMD, g869/ 7/2/07 Ertificate of D	ealth and Mo Death		giene Reg. No.	17 21170
	Dharatat	, i	1. Decedent's Name (First, Middle, Last)		2. Date of De		Year 3. Time of Death
	Physicia /Medio		Verlie Jeanette Moore		Sune	15 20	07 6 am M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death		4c. County of	
	7	<i>_</i>	Doctor's Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	u_	George's
	Funeral Director		243-20-3343 1 M 2 NF 99 Yrs. Months Days	Hours Min.	(Month, Da Jan. 25	y, Year)	9. Birthplace (State or Foreign Country) North Carolina
	p		Usual Residence of Decedent		0.000	7, -2	
	arylan show dat	-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	he Ma 18a-f	Director	Maryland Prince George's Mitchellville				1 XYes 2 No
1	with t		10e. Street and Number 10f. Zip Code			10g. Citizen of W	nat Country?
. 5	heath ms 23 musi	Funeral	1741 Albert Drive 20721 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sper	cify Yes or No	U.S.A. 14. Race	- American Indian,
16	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28e-f show event, the Medical Extrainer must be notified at	by Fur	1 Never Married 2 Married 1 Yes 2 No	, Mexican, Puerto F Specify:	Rican, etc.)	Specify:	s, White, etc. Black
CRUIE 21215-0036	2 hou latura ical E	ted	15 Decedent's Education 16a, Decedent's Usual Occupati	ion		16b. Kind of Bus	
215	thin 7 le. lan "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done duilife. DO NOT use retired)	ring most of workin	ng		
	filed with Hygiene. ether than	Co	12 Homemaker		/Final Middle	Own Hor	
and C	d be findal Hed out	Be		18. Mother's Name Lucy Out		maiden Surname	"
11,72	should nd Me mark matic	卢	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street an			er, City or Town, S	State, Zip Code)
Na Na	nd 2 saith ai		Geneva Hall (Daughter) 1741 Albert Dr.				
O. S. S. S. S. S. S. S. S. S. S. S. S. S.	es 1 a of He f Item		20a. Method of Disposition 1 ☒ BuriaL 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)) :	ate	20c. Location - 0	City or Town, State
Z E	Pag ment ant: It		4 Denation 5 Other (Specify) Zion Hill Baptist C	Church 6/	20/07	Colera	in, NC
$\mathcal{MOORE}_{j}\ V$ Baltimore, Maryland	permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once.		21. Sign ture of Fineral Service Linesee 22. Name and Address Reynolds Fu 321 Maple S	of Facility Ineral Ho St. North	me , Ahosl	kie, NC 2	27910
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	cy			Onset and Death
	/Medical		disease or condition resulting in death) a. Cerebrovascular Insufficient Due to (or as a consequence of):				
	Examiner	_	b. Cerebral vascular accident Due to for as a consequence of the cons				
V	ted nsit	nine	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
V ~	icate be executed physician and s the burial-transit	Examiner	that initiated events c				
68760,	te be ysicia ie bur	dical	d				
_		Medi	IF FEMALE:	_			
Вох	death certifi attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date Mon	e of delivery hth Day Year
P.O.	s that the de ned by the detached	hysi	9 ☐ Unknown 9 ☐ Unknown				
ds, F	p d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Renal Failure	ı in Part I.	m		bute to the cause of death? 3 ☐ Probably 4 ⊠Unknown
9	w requir	lete	Respiratory Failure		24a. Was	an 24b. W	Vere autopsy findings available
l Re	sician: The law certificate has t irector, page 2 s	Completed			autor perfo 1∐ Yes	osv l p	rior to completion of cause of eath? □Yes 2□ No
Vita	ician: Sertific ector,	Be	examiner?	26. Place of Death	(Check only o	nne)	
9	Phys	1	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 2	4 LI Nursing Hon		dence 6 Othe	
on	Attending Phradestr. After the by the funeral	tion	1 X Natural 5 □ Pending (Month, Ďaý Year) Injury Work?	es 2 □ No	iod. Describe i	now injury occurre	
Division or Vital Records,	l or Atter after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (8 City or Tox	Street and Numbe vn, State)	er or Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) and mar date and place, a	ner as stated. nd due to the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier 29c. License r	number		29d. Date signed	(Month, Day, Year)
			marun O welter D2374	.3		June 15	, 2007
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			Martin Weltz, M.D. 7525 Greenway Center Dr.,	Greenbe.	lt, MD		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2 2007 22. Registrar's Signature				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		irtment of F tificate of i		•	giene Reg. Na. 00	7 21171
í	Physici	an	1. Decedent's Name (First, Middle, La	SI) MCLAUGH LIN				2. Date of De Month	eath Day Ye	2 4 1 14
	/Medio		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Death	1 6	4c. County of [Death
	and the second	19	Washington Adve			Takoma		T		George's
	Funeral Director		5. Social Security Number 006-26-5761 Usual Residence of Decedent	7. Age (In yrs. In 78 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov 10	o, 1928	Birthplace (State or Foreign Country) unk
	yland low at		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar 8a-f sh tiffied	Director		George's Tal	koma P	ark				1 □Yes 2√ No
	th with th 23a or 24 ust be no	ral Dire	10e. Street and Number 7620 Maple Avenu			10f. Zip Code	20912		10g. Citizen of Wha	t Country?
036	be fled within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. V	Vas Decedent of H f Yes, specify Cuba □ Yes 2∏ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	5- 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's E (Specify only highest gra-	ducation (de completed) College (1-4or 5+) unk	16a. Deced (Give life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor d)	tritk king	16b. Kind of Busine	ess/Industry
ğ 2		Be Co	17. Father's Name (First, Middle, Last			unk	18. Mother's Nam	ne (First, Middle	, Maiden Surname)	unk
ylar	should be ind Mental marked o	ToB			1		<u>-</u>			
Mar	0 0 0		19a. Informant's Name/Relationship (Washington Adven						per, City or Town, Sta	
	es 1 and 2 of Health fitem 27 rother tra		20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of natory or other place	Avenue	Date Date	Park, MD 2 20c. Location - City	
Baltimore,	Pages ment of l ant: If its lury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Specif	y) in state			1			
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Emeral Service Licer Ronald S.	1 Sel O	→ Ba	Itimore.	MD 2120	0.1	. Baltimor	e Street
			23a. Part1. Enter the disease, or com shock or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RIGHT FRO		Cystic	oerse .	n of	BRAIN	Onset and Death
	Examiner		Paguantially list appditions	520 -5-55-5	CAN	er.				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ende of).					
,	execut n and lal-tran	Exan	that initiated events resulting in death) Last	c. CHRONIC Due to (or as a consequ	ence of):	RUCFIU	E LUNG	> DIS	EASE.	
68/60,	ficate be executed physician and s the burial-transit	edical		d HYPEKTEN	510 N	,				
ž X	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome pf pregnar	nev					
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	'		23d. Date of Month	Day Year
ecords, P	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	derlying cause give	en in Part I.			e to the cause of death?] Probably 4 □Unknown
ပ္	law as b 2 sh	Completed						24a. Was		e autopsy findings available to completion of cause of
-	ate pag							perfo 1∐ Yes	ormed? deat	h?
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	R/Outpatien	3∏ DOA Othe	26. Place of Dea er: 4 □ Nursing H		one) idence 6 □Other (Specify)
on or	ding Phys th. : After this s funeral di	!-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Work			how injury occurred	эреспу)
DIVISION	To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To		r Rural Route Number,
	te Hospit	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne , date and place, and	or as stated. due to the cause(s)
	to the within To the comp	Me	29b. Signature and title of certifier	alt:		29c. License			29d. Date signed (M	
)			Kajel Derf			646	077		6/20/0	7
			30. Name and address of person who	A ; HOSPETALI	SF,	7600 C	Anou Ai	SUNS	TAKONA P	AKH MD
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2 2	32. Registrar's Signat	tre	ale				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** June 24, 2007 Casper L. Matthews 6:39 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Corsica Hills Nursing Center Queen Anne's Centerville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Ane (In vrs. last birthday) **Funeral** 1⊠M 2□F 78 Dec 3, 1928 Director 213-24-0286 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County 27 is marked other than "naturel", or items 23a or 28e-f show traumetic event, it a Medical Exertiner must be notified at 1 ☐ Yes 2√∑ No MD Queen Anne's Church Hill Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21623 223 Buzzers Lane USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Importent: if liem 27 is marked other than "naturel", or Itel eny injury or other treumetic event. In ematical Exercises 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII/Kor 1 ☐ Yes 2 X No Specify: black Specify: 3 ☐ Widowed 4 🕅 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer Campbell Soup Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casper Matthews Mattie Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 N. Broadway #203 Baltimore, MD Dexter Matthews/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 ☑Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signals to o Euneral Service Licensee Ronald S. Wade Director 23å. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRI) To pulliway

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner + Newia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ь in the past 12 months? 4□Pregnant at time of death signed by the at d be detached fo 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown peen ADVanced Doment. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 1 Yes 2 No i or Attending Physicien: after death. erei Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 PNo 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 29a. Certifier 🛮 🙋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/25/07 123889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 Hogh Street, CHesten town, Wed 21620 John C. ARRABAL IN, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 0'Day 28 2007 Lucinda F. June 4:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 12 Mollie Court Phoenix | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 9 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** . 1949 1 □ M 2 🔀 F 58 070-38-6355 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits works r 28a-f show notified at 1 ☐ Yes 2 → No Md. Baltimore Director Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 12 Mollie Court 21131 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or item 1 □ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. 2 Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Lods Patricia Ryan ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. O'Day/ Son 12 Mollie Ct. Phoenix, Md. 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sheridan Park Crematory 7-2-07 Tonawanda, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral/Bervice Lice 23a. Part1. Enter the disealle, or comit cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BRAST CONEZA METASTATIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4⊡Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ

signed by the aftending physician and I be detached for use as the burial-trar To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Completed

Be

Certification:

Medical

State

Registrar

1 Yes 2 No 3 Probably 4 Unknown 24a Was an

1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 1 No

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined

Other: 4□ Nursing Home 5□ Residence 6 2 Other (Specify) 500 5 Home 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

20018320

RD. Lotter ville

29d. Date signed (Month, Day, Year) 26 07.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TALLS

John न्द्रारि 10753 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

0 2 2007

		1 - For State of Maryland /	Department of Health and M Certificate of Death	ental Hygier	from Color I had a fine of	
Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) 30hn Pollard		June ;	Day Year 3. Time of Death 24, 2002 8/30 M	
Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number) BON SLEOUXS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last b) 229-62-4286 12M 2DF 58		8. Date of Birth (Month, Day, Yea	Ac County of Death Baltimore City 9. Birthplace (State or Foreign Country) 17 UNK	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Exercities at	Director	MD Baltimore P.	wn or Location Cal Limore		10d. Inside City Limits 1底Yes 2 ☐ No	
s 23a or 2		2000 West Baltimose			Citizen of What Country?	
5-0036 72 hours after de natural, or Itemalical Evandon	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
ING 21215-0036 be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23a or 28a-f show avent, the Medical Exact in writings be recited at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0	Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	unk 166.	Kind of Business/Industry unk	
Maryland 2. d 2 should be filed v th and Mental Hygie ?7 is marked other t traumatic avent, II	To Be C	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	(First, Middle, Maide	en Sumame) unk	
E = 14 F		Bon Secours Hospital	b. Mailing Address (Street and Number or Rural 2000 W. Baltimore Stre			
daltimore, rmit. Pages 1 ar partment of Hea portant: if item?		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ② Other (Specify) in State	of Disposition (Name of ery, crematory or other place)	ate 20c.	Location - City or Town, State	
Baltim permit. Pac Department Important: any injury once.		21. Signature Funeral Service Licensee Made, Director	State Anatomy Board Baltimore, MD 2120	1	altimore Street	
Pnysician /Medical	: 17	23a. Pan . Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	NO Foilure	r respiratory arrest,	Approximate Interval Between Onset and Death	
be executed Executed	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the co	mental states	signdre		
death certif de attending e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year	
Sign is	leted by PI	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death? 2 🗆 No 3 🗆 Probably 4 🗘 Unknown	
The taw The taw te has b	e Complete	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No	
To the Hospitel or Attanding Physicien: To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this cartifica completely illied in by the funeral director, a	ToB	examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigation Natural 5 Accident New Year No Spiral: Month, Day Year No Spiral: No	utpatient 3 DOA Other: 4 Nursing Hom	a (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
itel or Att us after de ral Direct	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
the Hosp nin 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledg Medical Examiner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death occurre	d at the time, date ar	nd place, and due to the cause(s)	
To To Con	Σ	29b. Signature and title of certifier Jloance J. James A.	29c. License number D3 7203		ate signed (Month, Day, Year) JE 84 (2007	
		30. Name and address of person who completed cause of death (Item 23a) Terwa: L. Anb no Bo		e Hospathu.	Boltinane M.D	
Sta Registra		31. Date filed (Month, Day, Year) JUL 0 2 2007 ARegistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	-	epartment of r Certificate of			g. No.	
			Decedent's Name (First, Middle, La	st)				2. Date of Death	-	3. Time of Death
	Physici /Medio		Merna F. Pelczar					June 20		11:40 AM ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County of De	eath
			300 Avalon Farm	Lane Box 1:	33	Ches			Queen	
	Funeral		5. Social Security Number 6. S	Sex 7. Age I□M 2⊠F	(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	Sinthplace (State or Foreign Country)
7 3	Director		212-52-5389 Usual Residence of Decedent		92 "	3.		Sept 14	, 1914 I	owa
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man	to	MD Queen A	nne's	Chest	er				1 □ Yes 2 □ No
	ih the or 28,	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	15 will	Funeral Director	300 Avalon Famr	Lane Box 13	33	216			USA	
	r dee	Tue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
Maryland 21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. After than "natural", or Items 23a or 28a-f ehow Int, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 X No	Specify:		Specify:	white
5-0	72 h	Completed	15. Decedent's E (Specify only highest gr		(0	ecedent's Usual Occur Give kind of work done	during most of work	ing	6b. Kind of Busines	ss/Industry
121	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5-	-)	ife. DO NOT use retire	d)	.	h o = 1 #h o = =	
2	Hygie ther int, it	ပိ	17. Father's Name (First, Middle, Last	_	1.	nurse	18. Mother's Name		healthcar faiden Sumame)	e
an	d be Bental Ked o	To Be	Monte Gray Foss				Louise	Evangeli	ne Bedard	
37	should nd Men r marke umatic	F	19a. Informant's Name/Relationship	Type, Print)	19b. N	Mailing Address (Street	and Number or Run	al Route Number,	City or Town, State	, Zip Code)
	and 2 salth a n 27 is		Michael Pelczar/	spouse	30	00 Avalon F	arm Lane	Box 133	Chester,	MD 21619
Baltimore,	t to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci		20b. Place of D cemetery,	Disposition (Name of crematory or other pla		Date 2	20c. Location - City	or Town, State
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature Puneral Service Lice		ctor	22. Name and Addre State Anat Baltimore,	omy Board	655 W.	Baltimore	: Street
	_		23a. Part. Enter the disease, or conshock, or heart failure. List only	aplications that caused	the death. Do no				est,	Approximate Interval Between
	Physician		Immediate Cause (Final							Onset and Death
*	/Medical		disease or condition resulting in death)		consequence of	OTIC PAN	dra VAIIVI	115 111	(21) [7 4000
-	Examiner		Sequentially list conditions	b					··	
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):				
	ificate be executed g physicien and es the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of).				
68760,	be e)	a E				,.				
587	ficate phys	edical		d						
P.O. Box	The law requires that the death certi sie hes been signed by the ettending bage 2 should be deteched for use e	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpmths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of o	delivery Day Year
	s thet	by Pr	Part II. Other significant conditions	contributing to death bu	t not resulting in t	the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	w requires to been signer should be a	d be						1 □ Ye	s 2 No 3	Probably 4 @Unknown
Records,	aw resistance	Completed						24a. Was ar	24b. Were	autopsy findings available to completion of gause of
R	vsician: The lav iis certificate hes director, page 2	E						autopsy perform	ned? death	?
Vital	artifica ctor.	Be	25. Was case referred to medical examiner?					h (Check only one	9)	
of V	Physician: this certificant	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier		ALIGHT 3 DOA			nce 6 Other (S	pecify)
Ē	Jing P	lon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
isio	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not to	e Rises et leiu	nı . At home fare	M 1]Yes 2□No	28f Location (St	reet and Number or	Rural Route Number,
Division	tel or A rs efter al Direct	Certif	4 Homicide determined	building, etc.	(Specify)	n, street, factory, office		City or Town	, State)	
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: Atter th completely filled in by the funeral	Medical Certification:	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysicien: To the best o miner: On the basis of and manner stat	examination and	death occurred at the ti for investigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)
	withii To th	ž	29b. Signature and title of certifier	4/1	11	29c. Licens	se number	29	d. Date signed (Mo	onth, Day, Year)
			Londy //	Solm	Enson	D D3	1466		6/25/	07
			30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)	7 / -		,	
			30 3 Cyn Wool	d Drive	EASTO	~ MD	2/60/			
7	Sta Registi		31. Date filed (Month, Day, Year)	2007 32 negistra	r's Signature	Sportes				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** JUNS 10 M Mary Elizabeth Poble
4a. Facility Name (If not institution, give street and number) 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore washing ton Medical Center

5. Social Security Number 6. Sex 12. Age (In yrs. last birthd 6100 Burnie If Under 1 Year If Under 24 Hrs. Anne Arondel 8. Date of Birth (Month, Day, 02/15 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 218-32-8406 1 □ M 2 🖼 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "instural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No EURN Director MT 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21144 Richfield USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Herbert mary E. Kasler ewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110\$ 19a. Informant's Name/Relationship (Type. Print) Paddlewhere Ct. Millersville, my Natalie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State Ladowridge 7/3/07
22. Name and Address of Facility Causin Elkroge 7/3/07 4 □ Donation 5 □ Other (Specify) e Greene Finerd Sie 21. Signature of Funeral Service Licenses any In Vougn Balto. MD. 21229 5151 Balto. Nat'L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ahoxia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-tran Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9□Unknown by 1 signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown ailur been sign 1 Tes Completed elliation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has b rector, page 2 s 500 50 **Division or Vital** - orona 25 Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 2 🔀 No 1 ☐ Yes 3□ D0A Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jashington Medica 31. Date filed (Month, Day, Year) State 2000 02

DHMH 17 Rev 1/2001

Registrar

JUI

rank Pucillo	State of Maryland / Departr 1- For State Certifi Registrar Certifi	nent of Health and Mental cate of Death	Hygiene Reg. No	. 2007 211	17
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) FRANK PUCILLO		2. Date of Death Month Day June 26, 2007	3. Time of Death 0453 hrs	
Mg. a.	4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location of Dea		c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (in yrs. last to 158 - 56 - 2378 1 X M 2 F 47		Irs. 8. Date of Birth (MN Jan 16,	M/DD/YYYY) 9. Birthplace (State or Foreign	rse
daryland 28a-f show any 1 donce	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Macyland Baltimore County	vn or Location Towson		10d. Inside City Lin 1 Yes 2 X	-
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 1638 Hardwick Road	10f. Zip Code 21286	10g. Ci	itizen of What Country? USA	
er death with t , or items 23a r must be not Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced of Services Armed Forces? 1 Yes, 2 X No	13. Was Decedent of Hispanic Origin? (If Yes, specify Ouban, Mexican, Pue 1 Yes 2 X No specify:		14. Race - American Indian, Black, White, etc. Specify: White	
5-0036 ed within 72 hours aft lygiene. other than "natural" the Medical Examine. Completed by	or Dates:	a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use Laborer	retired) ^	Kind of Business/Industry Food Services	
211 be fill htal F ked ent, 1	17. Father's Name (First, Middle, Last) Frank J. Pullico, Sr.	18.Mother's Na	me (First, Middle, Maide verly Ann Ba	n Surname)	
MD 21 nd 2 should I slith and Mer m 27 is man aumatic ev	19a. Informant's Name/Relationship (Type, Print) Frank J. Pucillo, Sr. (Father)	19b. Mailing Address (Street and Number 31 Lansdale Drive,	and the second s		
Baltimore, ME permit. Pages 1 and 2 si Department of Health an Important: If item 27 injury or other-trauma	1 Burial 2 X Cremation 3 Removal from State Gree 4 Donation 5 Other Specify:	e of Disposition (Name of cemetery, natory or other place) an Mount Crenatocy 6	/30/2007 B		d
Balt permit. Depart Import	21. Signature of Juneral Since Lee see Martin D. Lawson 23a. Part I. Enter the disease, or complications that caused the death. Do	22 Name and Address of Facility Mitchell—Wieder 6500 York Road.	eld Funeral Baltimore,	Home, Inc. Maryland 21212	
Physician /Medical :aminer	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and chest in Due to (or as a consequence of):		c or respiratory arrest, sl	hock, or heart Approximate Inte Between Onset Death	
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Under the Company of the Compa				
50, te be executed ysician and burial - transit	TXUNPENDED AMENDED #23a .PII .27 .28a-f.	perMF0869. 7/19/07 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical Estedical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pre	17	3d. Date of delivery Month Day Year	
P.O. B s that the d med by the catached by Phy	Part II. Other significant conditions contributing to death but not resu Atherosclerotic cardiovascular disease			o use contribute to the cause of death	
Division of Vital Records, P.O. Box 6876 within 24 hours after death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phe completely filled in by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/IV	Atheroscierotic cardiovascular disease		24a. Was an autopsy performed		e of
tal Rectan: The certificat	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FE	26.Place of Death (Che	ck only one)		
n of Viding Physical After this funeral distriction: To	1 V Yes 2 No	b. Time of Injury 28c. Injury at Work? 1 Yes 2 X No	28d. Describe how in	dence 6 Other:	
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation FNd 6/26/2007 1	nk. , farm, street, factory, office building, etc.		t and Number or Rural Route Number,	City
To the Hospi within 24 hos To the Fune completely fi	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurre	and due to the cause(s) and at the time, date and p	place, and due to the cause(s)	
Ž	29b. Signature and title of certifier (Dec de l'Hella	29c. License number O.C.M.E.		d. Date signed (Month, Day, Year) Ine 26, 2007	
07	30. Name and address of person who completed cause of death (Item 23 Carol Allan, MD Assistant Medical Examiner 17	a) 1 Penn Street, Baltimore, MD 21	201		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHMH 17 Rev 1/2001 OCME 2006	DCMF	DRIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 5: 40 AM 9 ROGERS SAAC 2007 une /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital linton PRINCL George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 66 241-62-6167 Edgecombe N C 04/04/1941 Director Usual Residence of Decedent 3a or 28a-f show it be notified at Prince Georges 10c. City, Town or Location Clinton, Maryland 10a. State MD 10d. Inside City Limits 1XXYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20735 6804 Surratts Road an "natural", or items 238 Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 □ Yes 2X No B1ack Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Medionce. Elementary/Secondary (0-12) Self-Employed Electrical Enginer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Jones Isaac Cephus Rogers Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7700 Featherstone Dr. Raleigh, N C 27615 Tyrone R. Byrd (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 11,07 | Washington, D C Howard Univ School 4℃Conation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service 3821 14th Street N W Washington, D C 20011 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Event **Physician** Ischemic /Medical Due to (or as a consequence of) Examiner In controlled squentismy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner uncontras/le burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autonsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the as attending p the signed by t peen has page 2 certificate director, this funeral the

and

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

items 23a or

To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t filled in by Medical completely

7503 State

29a, Certifier

(Check only one)

cholienbrun

29c. License number 02626

WD.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R2 Clinton SURRATTS

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #20b, perFH, g869. 7/2/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **FLORETTE** RUTTENBERG JUNE 2007 8:36 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8011 MELODY LANE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Days Months 1 □ M 2 ₩ F Hours 09/13/1928 78 Director 215-48-2824 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10d. Inside City Limits ⊓s 23a or 28a•f shov must be notified at **Funeral Director** 1 ☐ Yes 2 No MD **BALTIMORE** BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 8011 MELODY LANE U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 N No 1 ☐ Yes 2 No WHITE Specify. Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 **OWNER** CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **HARTZ** UNOBTAINABLE MARVIN BESSIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8011 MELODY LANE - BALTIMORE, MD 21208 LEWIS RUTTENBERG / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/29/2007 06/28/2007 OHEB SHALOM MEMORIAL REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Month Len 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CANCER 8 yers a. LUNE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or moury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician s the burial Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTUE PULLVINNY 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ro 24a. Was an autopsy 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 🔀 🕼 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manper of Veath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natura 2 Accident I Director: A death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

Registrar

State

29b. Signature and title of certifier

30. Name and address of person

W. Huns

Shartan m0 10753 32. Registrar's Signature

MD

no completed cause of death (Item 23a) (Type, Print)

Rd #415 Falls

29c. License number

038709

Coprelle

29d. Date signed (Month, Day, Year)

21093

6/28/07

21180

		1 - For State Registrar		State of IMa	iryland /90ep Ce	ertificate of l			eg. No.		-1100
		1. Decedent's Name (Fir						2. Date of Dea	th _Day	Year	3. Time of Death
Physi /Med		Josep		vis Stew	enson S			June	28	2007	12110 AM
Exan		4a. Facility Name (If not				1 1 1 1	Location of Death			nty of Death	
		1415 1		nd St.	/la ura last hirthda	1111	M ove	8. Date of Birth			place (State or Foreign
Funera Directo		5. Sort Pecurity Number 276-16-3	396 X	X 2M 2□F 26	o (In yrs. last birthday Yrs.	Months Days	Hours Min.	June 12	Year)	Coul	min)
and w		Usual Residence of Dec 10a. State 10b	c. County		10c. City, Town or L	ocation					10d. Inside City Limits
Maryl fehc	ğ	Mit.	N/A	_	BALTIN	noce.					1 Yes 2 No
28e	Je C	10e. Street and Number			00,7770	10f. Zip Code		1	0g. Citizen o	of What Cou	ntry?
h with	0	1415 1	V. Ban	d 5.T.		2	1213		21	15,A	,
deep deep	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?		. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri	
A I A I D-UU.DO Id within 72 hours after deeth with the Maryland Id gigne. er then "natural", or Itams 23e or 28e-f ehow if the Medical Examinar must be notified at	b	1 Never Married 3 Widowed 4		Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:	INTL	1 ☐ Yes 2 🔀 No	Specify:		Spe	cify: B/	ACK
72 ho	Completed		Decedent's Edu	cation	16a. Dec	edent's Usual Occup	during most of work	ing	16b. Kind of	Business/In	dustry
S 2	d d	Elementary/Secondar	y (0-12)	College (1-4or 5	+) life.	DO NOT use retired	d)		0.	ota	
0 5 2 -		17. Father's Name (First		Non	6	nstruct	18. Mother's Nam			STEUR	(1,0N
be do	Be	17. Father's Name (First	, MIGGIO, Last)	Beaus				,			
should and Men a marke umatic	P	19a. Informant's Name/	Relationship (T	VOA Print)	19b. Mai	ling Address (Street	and Number or Rui	al Route Numbe	r, City or Tov	vn, State, Zij	p Code)
16, IVICITY ICS 1 and 2 should 1 Health and Mer Item 27 is marked other traumatic		151- Jaho	Th <	Tevenson	14	SN BOD	det B	2/Timor	a mi	212	13
Heal Heal	1	20a. Method of Disposit			20b. Place of Disp	position (Name of ematory or other place		Date	2 Locatio	n - City or T	own, Slate
* # O		1 Burial 2 Cr 4 Donation 5		Removal from State)	- N	son Forest	- Lui	16,2007	Devia.	es Mil	Is mo
permit. Page Department (importent: if	ej.	21. Signature of Funera				22. Name and Addre	ss of Facility	Hone			01515
Departing on your	ă	() tale	ica !	Sells		BeTTF, 24	ss of Facility	01.10 5	7.6.	7-170.	mo.
1175		23. Fart1. Enter the di	isease, or comp	olications that caused one cause on each lin	the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition		1	y cancer						2 years 10 mm
/Medic	31	resulting in death)			consequence of):						1000
Examine		Sequentially list condition	ons.	b							
P #	le le	cause. Enter Underlyin Cause (Disease or injur	nate g	Due to (or as	a consequence of):						
ecute and I-trans	Examiner	that initiated events resulting in death) Last		c. Due to (or as	a consequence of):					-	
be ey	一面			540 10 (0: 40	2 00/100 420/100 01/1						
ficate be executed physicien and is the burial-transit.	edical			d					-		
OI VILGI NECOLOS, T.O. DOX OF Physician: The law requires thet the death certifical this certificate has been signed by the attending priral director, page 2 should be detached for use as it	Ž	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outcome					23d.	Date of deliv	very
death death death death	Physician/Me	in the past 12 mor 1 □ Yes 2 □ No	nths?	4☐Pregnant al		□Ectopic pregnancy □ Other (specify) _	<i>y</i>			Month	Day Year
that the ded by the detached	hys	9 Unknown		9□ Unknown				-			
res thet rigned to be deta	by P	Fait II. Other significan					en in Part I.		_		the cause of death?
w require been sig should b	ed L	Chron	10 005	trustive 1	ulmmany	Disease		1 ()3()	′es 2⊡No	3 🗆 Pro	babiy 4 Unknown
Tecology, The law requires t te hes been signe age 2 should be o	Completed							24a. Was autop		b. Were aut	opsy findings available ompletion of cause of
The The Sete he page	ĕ							perfo	rmed? 2 X No	death? 1 🗌 Yes	2□ No
VICION: The certificate rector, pag	Be	25. Was case referred examiner?	13-				26. Place of Dea	th (Check only o	ne)		
OI VICAL Physician: T	၉	1 ☐ Yes 2 🕱 No			ent 2 ER/Outpat		4 □ Nursing ⊓	ome 5 Resid			ıfy)
Jn C ding P Altert funera	on:	27. Manner of Death 1 Natural 5	Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injun	/ Wo		28d. Describe h	now injury oc	curred	
Sicological Sicolo	Certification:	2 Accident 3 Suicide 6	investigation Could not be	-	ury - At home, farm,		Yes 2 □ No	28f Location /5	Street and Ni	imber or Ru	ral Route Number,
LIVISION I or Attending after death. Director: After	it.	4 Homicide	determined		c. (Specify)	street, factory, office		City or Tox	m, State)		,
UNUSION OF VICE To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.		29a. Certifier	Certifying Ph	ysician: To the best	of my knowledge, de	ath occurred at the ti	me, date and place	, and due to the	cause(s) and	I manner as	stated.
e Hos	Medical	(Check only 2 one)		niner: On the basis of	f examination and/or	investigation, in my	opinion, death occu	rred at the time,	date and pla	ce, and due	to the cause(s)
To the within Fo the complex	Me	29b. Signature and title	of certifier			29c. Licens	se number		29d. Date si	gned (Month	, Day, Year)
- >= 0) A	antil	hn		80	1035363	s	7	12/07	
9		30. Name and address	of person who	completed cause of	death (Item 23a) (Typ	e, Print)	0 0	D			
D	State	Sandra 31. Date filed (Month, I		CUMD B	death (Item 23a) (Types AMC Urar's Signature	o North	Greene St	. Kal	more	MD?	L/201
	strar	JUL	0 2 2007	Bleeve	IS Appe	ALL P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Amend 29d, perMD, g869, 7/2/07 TT Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:50 PM Stephen F. Sakalski June 2007 al 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER BALtimore Rosedale If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1**X** M 2 □ F 85 043-12-6940 12-16-1921 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 U.S.A. 4 Troon Ct 12. Was Decedent Ever in U.S. Armed Forces? 1♣ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Sakalski Mary Rok 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11824 Robinwood Dr Hagerstown, MD 21742 Stephen G. Sakalski (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-23-2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sever Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

28a-f show must be notified at

ö

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must to once.

ith and Mental F. Pages 1 and 2 should be

Director

Funeral

þ

Be Completed

2

filed within 72 hours after death with the Marylar

*SA KALSK*パー Sい Baltimore, Maryland 21215-0036

/Medical

10a. State

Examine burial-trar physician a the burial Physician/Medical attending pl ρ Completed ate has bage 2 s this certific al director, Be P Certification: After within 24 hours after death

To the Funeral Director:
completely filled in by the

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No
9 🗆 Unknown

	ions contributing to death but not resulting in the underlying cause given in Part
Acute Genal	Earling.

25. Was case referred to medical examiner?

2 No 1 ☐ Yes 27. Manner of Death 5 Pending investigation 2 Accident 3 ☐ Suicide

4 Homicide

29a, Certifier

6 □ Could not be determined

1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an

autopsy performed? 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

June 21, 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

waciunemen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square DRIVE BALLIMOTE, MARYland 21237

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

D

Medical

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of De Examiner 9109 Libert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace **Funeral** Days Hours 1 M 2 F Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Completed 27 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT,use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relatio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important; If item 27 Is any Injury or other trau 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Vicens Approximate Interval Between Onset and Death 23a. Part. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on , ach line. Immediate Cause (Final disease or Indition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequendary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If ves, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) P.O. should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 217110 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 autopsy performe rector, page 2 2 3 N To the Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes Other: Certification: To 2[]_NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifiei 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) signature and 29b 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed

Registrar

State

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day George June 30,2007 3:04p Silverberg 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville If Under 1 Year If Under 24 Hrs. Hebrew Home of Washington Montgomery 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth Month Day Year 2715/1909 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 143-18-8437 1 3M 2 ☐ F 98 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Montgomery Silver Spring 1 ☐ Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 14508 Homecrest Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hardware Store Owner 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Silverberg Lottie Janowsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3904 Calverton Drive Hyattsville, Md20782 Dr.Robert F.Silverberg/Son 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 8urial 2 □ Cremation 3 □ Removal from State Beth Israel Cem. 7/02/2007 Woodbridge, N.J. 5 Other (Specify) 4 Donation 21. Signatury of Funeral Service Licensee PHILIP ADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THERO SCLEROSIS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the atlanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

or Itams 23a

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If itam 27 is marked other than any injury or other traumatic avant, Ita Maonee.

Physician

/Medical

Physician/Medical Examiner

Completed by

Medicai Certification; To Be

Director

Completed by Funeral

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

other traumatic avant, the Medical Examiner must be notified at

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 Tyes investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

31. Date fited (Month, Day, Year)

DO18084

July 01, 2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTROSE RD ROCKVILLE MD 2085.

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 11:55p Robert Berwager Simpers 29 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) April 11,1925 9. Birthplace (State or Foreign Country) 25 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 82 Director 219-14-9589 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at oncies. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Carroll Manchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3637 Watertank Rd. 21102 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ĩ2 Service Man Propane Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George F. Simpers, Sr. <u>Flora Berwager</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Simpers - wife 3637 Watertank Rd. Manchester, Md. 21102 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cem. July 3,2007 Manchester, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Hull Ell 3296 Charmil Dr., Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Week erebro Vascular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Dove House Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

とろし

To the

29c. License number

29d. Date signed (Month, Day, Year)

7007

and manner stated.

Storer

istrar's Signaty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar	0.0.0	ar y rarro		rtificate of l			Reg. No.	07)	105
*	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month		Year	3. Time of	
	/Medic		James Simpson					1	Jone		2007	4.55	/4 M
)	Examir	ier	4a. Facility Name (If not institution	n, give street and number)	Him	re	104111	Morc	city	4c. County	or Death		
20.064	Funeral Director		5. Social Security Number 217-34-6627	6. Sex 7. Ag	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Min. 8. Date of Birl Month, Da May 31,	1941	9. Birthpl Count	ace (State o	or Foreign unk
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside C	ity Limits
	a-f sh	ctor	MD		Bal	L ti mo:	re					¹ ▼Yes	2 □ No
	with the	Dire	10e. Street and Number 3406 Fairview	Avenue			10f. Zip Code	21216		10g. Citizen of \	What Coun	try?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status un 1 Never Married 2 Mari 3 Widowed 4 Divorced	k 12. Was Decedent Armed Forces?	Ever in U.S	1	Uwas Decedent of Hif Yes, specify Cuba		? (Specify Yes or No uerto Rican, etc.)		ce - America ck, White, e y: bla	etc.	
9	r2 hou natura Ical E	ted	15. Deceden	t's Education st grade completed)			dent's Usual Occup kind of work done of		unk	16b. Kind of B	usiness/ind	ustry	unk
21215-0036	within 7 sne. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retired	duning most or	WORKING				
d 2	il Hygie other t	Be Co	unk 17. Father's Name (<i>First, Middle,</i>	lunk Last)			unk	18. Mother's	Name (First, Middle,	Maiden Surnan	ne)		unk
ylan	ould be Menta arked atlc ev	To B											
Maryland	d 2 sho th and 7 Is ma trauma		19a. Informant's Name/Relations	hip (Type. Print)					r Rural Route Numbe	_			
	es 1 and of Health filtem 27		SInai Hospital 20a. Method of Disposition		20b. Plac	2401 ce of Dispo	W. Belve osition (Name of matory or other place	dere Av	venue Balt	20c. Location		1215 wn, State	
Baltimore,	Pages ment of I ant: If It		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📉 Other (S	3 □ Removal from State Specify) in state		notory, oron	natory or other place						
Balt	permit. I Departm Importar any Inju		21. Signature of Funeral Service Ronal &	Licensee By Walle Dir	ector	S	2. Name and Addres State Anai Baltimore	tomy Bo	ard 655 W 1201	. Baltin	more S	Street	
			23a. Part1. Enter the disease, or shock or heart failure. List	complications that caused only one cause on each li	the death.		ter the mode of dyin			rrest,		Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Mul1	Togac	Nic f	adure					Onset and	Death CCAC
	/Medical Examiner			Due to (or as	a conseque	nce of):						3 w	eeces
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to three	a conseque	nes of):	feuture					3 45	eeces
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):							
68760,	rtificate be executed ng physician and as the burial-transit			d									
		Medical	IF FEMALE:										
P.O. Box	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. if yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	′			ite of delive onth		Year
	res that igned b be deta	by	Part il. Other significant conditi	ons contributing to death b	ut not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cont			
Sorc	v requi been s should	eted										5	72
Re	hysician: The law his certificate has I I director, page 2 s	Completed							— autor	osy rmed?_	prior to con death?	osy findings npletion of c 212 No	ause of
/ita		BeC	25. Was case referred to medica examiner?						Death (Check only o		1 1 1 1 0 3	2,42,110	
Or	D → Ø	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatier		4 LI Nursir	ng Home 5 Resident	dence 6 Oth		')	
ion	Attending Physician: r death. ector: After this certification of the funeral director, it	ation	1 Natural 5 Pendir 2 Accident investi	ng (Month, Da	y Year)	Injury	Worl	k? Yes 2∐No	Edd. Bedonber	iow injury occur			
Division or Vital Records,	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined Zoe. Flace of Inj	ury - At hom c. (Specify)	e, farm, str	reet, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	ber or Rura	Route Nur	nber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	f examinatio	edge, deat n and/or ir	h occurred at the tir vestigation, in my o	ne, date and popinion, death	place, and due to the occurred at the time,	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifie	r D			29c. Licens	e number		29d. Date signe		-	
			Mar	"Soulin	, Mo		1665	- 000		June 2.	5,20	07	
			30. Name and address of person OSCAR BALLO 31. Date filed (Month, Day, Year)	who completed cause of c	leath (Item 2	3a) (Type,	mital of	Bultin	wre				
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	ar's Signatu	re	aut.						
	Registi	ar	JUL 0 2	LUUI DECLA	UM	14							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

		1	State Registrar			Certificate	of Dea	ath	Re	g. No.	0.87	22118	}
Physic			. Decedent's Name (First, Middle, Las	" Serie	0				2. Date of Death Month	Day	Year 2007	3. Time of Death 255 PM	
/Med Exam			a. Facility Name (If not institution, give		/P	hep 4b. City, To	own, or Loca	ation of Death	e		unty of Death		
Funera Directo			5. Social Security Number 6. S 577–40–5009	ex 7. Age (□ M 2 X F	n yrs. last bir 82	thday) If Under 1 Yrs. Months		Jnder 24 Hrs. ours Min.	$^{8.\ \text{Date of Birth}}_{\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $	Year) 1924	9. Birthpl Coun Mary1	ace (State or Foreig try) and	n
ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	otocaio le	Director	Journal Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 2525 W. Belvede		Oc. City, Town		ode 212	215	10		of What Coun	0d. Inside City Limits 1√ Yes 2 No try?	
hours after deat ural", or items :	1	Dy rui	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decede If Yes, specif 1 ☐ Yes 2		nic Origin? (Spe lexican, Puerto pecify:		Sp	Race - Americ Black, White, o ecify: whi	etc. te	
J within 72 ho giene. r than "natu the Medical		palaidilloo	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unk	ducation de completed) College (1-4or 5+) unk	16a	Decedent's Usual (Give kind of work life. DO NOT use disabl	done durin retired)	n ig most of work	ing	none	of Business/Ind	dustry	
yland a filed Mental Hygarked othe attic event,	0 0 0 1	0	17. Father's Name (<i>First, Middle, Last,</i> James Thomas M	urphy				Ethe1	Jewell.				
t, Ivia: 1 and 2 sho Health and em 27 is m ther traum			19a. Informant's Name/Relationship (Ethel Kerns/sistem 20a. Method of Disposition		2 20b. Place o	b. Mailing Address (4 Mooncoi of Disposition (Name	n Cir	cle Wal	Ldorf, M	206			_
tmer tant	ย์		1 Burial 2 Cremation 3 4 Donation 5 Mother (Specification of Funeral Service Licer) in state		ery, crematory or oth		f Facility	655 W.	Ro1+:	imara S	troot	
Depariment of the policy of th	ouc	-	23a. Part1. Enter the disease, or comshock, or heart failure. List only	1XIII	•	Baltimo	re, M	D 2120	1		Illore 3	Approximate Interval Between Onset and Death	
death certificate be executed death certificate be executed Examine e attending physician and directions as the burial-transit	al er	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a decomposition) b. Lue to (or as a decomposition) c. Due to (or as a decomposition)	SCR consequence	eniz (91 91): 19 of):	stic	Jases	dar of	is Co	75	Onset and Deam	
death certif	1.5	nysician/iwec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	☐ Fetal deat	h 3 ⊟Ectopic pre 5 □ Other (spe				23d	I. Date of delive	ery Day Year	
requires that the een signed by the	2	Dy P	Part II. Other significant conditions	contributing to death but	not resulting	in the underlying ca	use given ir	n Part I.		oacco use		he cause of death?	/n
al necolu : The law requir cate has been si ; page 2 should I		Completed								med? 2 A No		ppsy findings availab mpletion of cause of 2月 No	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		tion: 10 Be	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b.		Other: Bc. Injury at Work?	4 X Nursing H	th (Check only or ome 5 Residence 28d. Describe he	ence 6 D		(y)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of injury building, etc.	(Specify)	arm, street, factory,	office		City or Tow	n, State)		al Route Number,	
Fo the Hosp within 24 hou Fo the Fune completely fil		Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	hysician: To the best of miner: On the basis of e and manner state	examination a	ind/or investigation,	in my opini	ion, death occu	rred at the time, o	late and pl	nd manner as s lace, and due t signed (Month,	o the cause(s)	7
->-0			30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)) 15	503	h R	Jun	235	2000)
5	Stat	е	31. Date filed (Month, Day, Year)	3 Registrar	's Signature	Sall D	111	in S	1 De	112	m)	0/01/	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 28ay **Physician** 2007 01:54 PM ${ t RIEDEL}$ SLACK ERIKA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth
(Month, Day Year)
Dec. 15,1919 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Germany 1 □ M 2XXF 87 **Director** 212-70-2279 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Towson Maryland| Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be i U.S.A. 1055 W. Joppa Road Apt. 441 21204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter ∐Yes ŽXNo fYes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXVIo Specify. If Yes, Give Year or Dates: à Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theophile Muehlen Clara Wilhelm ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1055 W. Joppa Road Apt. 441 Towson, Maryland 21204 Wyatt Cameron Slack (Husband) permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2XX remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6-30-07 Baltimore, Maryland Green Mount Crematory 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service/Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mora seresial henowha **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2□ No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

30. Name and address of person who complete

ed cause of death (Item 23a) (Type, Print)

trar's Signature

29c. License number

030433

BRUIMORE

29d. Date signed (Month, Day, Year)

21204

JUNE 29, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Harry F. Staub June 26 2007 05:01 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center **Baltimore** Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Country) PA Months Days Hours Min 1 🔀 M 2 🗆 F Director 211-16-5845 July 8, 1925 81 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21XNo Directo MD Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1021 Kenilworth Drive 21204 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other the any Injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No 14 Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo ģ If Yes, Give Year or Dates Specify White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SMaj. US Army Militarv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Staub Mary Haas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Swam (daughter) 9538 Gun Hill Circle, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cemetery 09/05/2007 Arlington, VA. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** u monal disease or condition resulting in death) /Medical r as a consequ Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in dooth). Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1□ Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 \sum Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Mariner of De 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical

State

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 29b. Signa

29c. License number

and manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print)

ertifie

07-04872 Tammy Stewart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

allilly Olewart		1- For State Certificate of D		Reg. 1	200	7 2113
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da	- ;	3. Time of Death
ledical Examiı		Tammy Lynn Stewart		June 26, 200	17	1633 hrs
			City, Town, or Location of Death		4c. County of Death Baltimore Cour	
		20 / 1109/1011/	OWSON If Under 1 Year If Under 24Hrs	R Date of Birth/A	MM/DD/YYYY) 9. Birth	
Funeral Director		, , , , , , , , , , , , , , , , , , ,	Months Days Hours Min		Foreign	ntry) Maryland
Director	-			Aug. 24	, 1907	- Hary Tanu
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
. ≜	_	Maryland Baltimore Towson				1 Yes 2 X No
daryland 28a-f show 1 at once.	ector		0f. Zip Code	10g.	Citizen of What Count	ry?
vith the Maryland \$ 23a or 28a-f shov 2 notified at once.	Dire	28 Alleghany Avenue #2203	21204		U.S.A.	
ms 23	Funeral		Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
r deat or ite	Fu	1 Never Married 2 Married 1 Yes 2 X No		10.4	Specific lilb	ite
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	à	or Dates:	es 2 X No specify: Usual Occupation (Give kind of	work done	Specify: Wh	
2 hour	Completed		of working life. DO NOT use ret			
336 thin 7 ne. than	gu	12 Sal	es	5	Retail	
5-0(led wi lygier other		17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Mai	,	
21215-0036 wild be filed within 72 Mental Hygiene. marked other than ic event, the Medical	Be	Daniel Guy Stewart	Pa	tsy A		1ff
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she native event, the Medical Examiner must be notified at once	٤	1	ddress (Street and Number or			
M 2 alth				Drive, AD	Oc. Location - City or	Fown, State
Baltimore, MD 2121. permit. Pages I and 2 should be fil Department of Health and Menna I Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 X Cremation 3 Removal from State crematory or other		2-2007	Towson M	aryland
Baltimo permit. Page. Department o Important: injury or oth	3				n Funeral	
Balt permit Depart Impor	4		50 York Road	Towson,	Maryland 2	1204
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	9	Immediate Cause (Final disease a. Multiple Injuries				Death
(diffile)		or condition resulting in death) Due to (or as a consequence of):				7
	- l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
In ted	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
execu an and al - tra	g	UNPENDED AMENDED				
760, cate be executed physician and he burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 ertific ding p			death 3 Ectopic pregr	ancy	Month D	Day Year
Box 687 (e death certifice the attending pleed for use as th	Physician/	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Othe	r (Specify)			
that the do			derlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
, P.C ires that signed I be deta	d by			1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requir s been s should I	lete	Ĺ		24a. Was an autopsy		topsy findings available completion of cause of
eco he law ate has	Completed		-	perform 1 ✓ Yes 2		es 2 No
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medical	26.Place of Death (Check	(only one)		
Vita hysici this c	To E	1 V Yes 2 No 1 Inpatient 2 Erroutpatient			esidence 6 Other	: Scene
ing Ph	E	27. Manner of Death 1 Natural 5 Pending Pround: Day, Year) 28a. Date of Injury 28b. Time of Injury FOUND: FOUND:	ury 28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe ho Subject precip	winjury occurred pitated from build	ling
ivisior or Attend after death. Director:	catio	Pending Pending Sun 26, 2007 1630 hrs 28e. Place of Injury - At home, farm, street,		28f Location (Str	eet and Number or Ru	ral Route Number, City
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the start death. To after death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	Suicide 6 Could not be determined (Specify) Local Street	ractory, office building, etc.	or Town, Sta		
Lospit 4 hour funer;			ed at the time, date and place, ar	id due to the cause(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred	at the time, date ar	nd place, and due to th	e cause(s)
F. wi	Me	29b. Signature and tile of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		+ NNI /t	O.C.M.E.		June 27, 2007	
6		30. Name and address of person who completed cause of death (Item 23a)	Charat Dallian MD (1201		
5		20 Districts Construe	Street, Baltimore, MD 2	21201		
S Regis	tate strar	77 37 (3 5) 7(11) / 184 a La A	E)			
DHMH 17 Rev 1/2			(a)			
	1	CHOMAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 5 CHULTZ ODM MM6MET 25 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Samari Baltimore 000 09 oi ta If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Days Hours 82 213-20-5377 Jan. 2, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Fullerton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sipple Avenue 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barthe1 J. Elizabeth Chaillou George Irene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Schultz/Husband 25 Sipple Avenue Baltimore MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 06/29/2007 Baltimore 21. Signature of Funeral Service Lic Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore 23a. Part1. Enter the disease shock, or heart failure. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm disease or condition resulting in death) Due to (or as a consequence of) rolio Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent prednant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 Ø No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

The law requires that the death certificate be executed attending physician a for use as the burial Box 68760. P.O. been signed by the should be detached Division or Vital Records, cate has , page 2 s this certificate or Attending Physician: director,

Physician

/Medical

Examiner

Physiclan/Medical After th funeral within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ပ

Examiner

Completed by

Be

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco.

examiner?	26. Place of Death (Check only one)									
1 Yes 2 No	Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3[□ DOA Other: 4 □ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Mann Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 ☐ Certifying Pt (Check only 2 ☐ Medical Exa	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	arred at the time, date and place ation, in my opinion, death occurrence.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)							
29b. Signature and title of certifier	e do Mes	29c. License number	29d. Date signed (Month, Day, Year)							

State Registrar

31. Date filed (Month, Day, Year)

02

2007

Jrch Harren Blvd 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day **Physician** AMES 1230 P 23, 2007 June /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 309 F Tall Pines Court Harford Abingdon 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) **Funeral** Days 216-14-8091 Months Hours Min. Director 85 1922 May 14, Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21009 U. S. A. 309 F. Tall Pines Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after cealth and Mental Hygiene. m 27 is marked other than "natural", or liter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland State Police 12 Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Gardner John J. Trammell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau once. 309 F. Tall Pines Ct., Abingdon, Maryland 21009 Barbara J. Trammell (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Granite Presbyterian
Church Cemetery Pages 1 Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 06/28/2007 Woodstock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -months **Physician** xastroesophagea /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) as been signed by the 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 2□ No or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ∏Yes 2 ∏No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 🔂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and the of ce 29c. License number 29d. Date signed (Month, Day, Year)

> h (Item 23a) (Type, Print) 1600 OS/Er

32. Registrar's Signature

Towson Md 21204

DHMH 17 Rev 1/2001

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Emmanuel Toche	1	- For State	e of Maryland /	Departme Certifica				Mental	Hygie		g. N o.	200	1	2.19
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle,L Emmanuel	ast) Toc	he					M	ate of Death	Dav	Year	3. Time (of Death) hrs
(4a. Facility Name (if not institution, of S/B 1-495 south of Rt. 50			4	b. City, To Lando		ocation of De	ath			nty of Deatl e George		
Funeral Director		212 60 2772	Sex 7. Age X M 2 F	(In yrs. last birt	hday) Yrs.	If Under Months	_	If Under 24		Date of Birth		YYY) 9. Bir Forei Co	rthplace (S Came	roon
rd how any ree.		Usual Residence of Decedent 10a. State 10b. County MD Montg		Oc. City, Town			g							de City Limits
the Marylan is or 28a-f s	Director	10e. Street and Number 3213 Hewitt	Avenue #T	1		10f. Zip (090	6		10	-	f What Cou		
2 hours afte "natural" Examine	Completed by Funeral	11. Marital Status 1 Never Married 2 XMarri 3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12)	1 Yes 2 ed If Yes, Give Year or Dates:	X No	1 Decedent	Yes 2	Cuban, I X No Occupation ing life. I	anic Origin? Mexican, Pue specify: In (Give kind DO NOT use	of work of	n, etc.)	Special Specia	of Business	Blac	
215-0036 e filed within 77 all Hygiene. eed other than nt, the Medical	Be Com	17. Father's Name (First, Middle, La Paul Mouofo	st)					3.Mother's Na		t, Middle, M		ame)		
MD 2121: d 2 should be fil th and Mental I in 17 is marked aumatic event,		19a. Informant's Name/Relationship Bridgitte Toc	(Type, Print) he/Wife	19	b. Mailing	Address 1 He	(Street	and Number t Ave	or Rural	Route Numi	lver	Spr	ing,	Md20906
Baltimore, I bernit. Pages I and Department of Heal Important: If Item injury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 4 Dongtion 5 Other Spec		20b. Place of cremate Park	of Disposi tory or oth Law	ition (Nam ner place) n Me	e of ceme m .P	k 5/	Dat 30/	e 2007		kvil		
		21. Signative of Funeral Servation 21. Signative of Funeral Servation 22. Signature of	ens		PH 92	TLTP 41 C	olu	ŔĨŅĀL mbia	DI Blv	FUNER	RAL S	ERVI Spri		A. Id20910 kimate Interval
Physician /Medical Examiner		failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	each line. a. Head, Neck and Due to (or as a consect b.	Chest Injurquence of):		ie mode o	r dyllig, s	udi as cardia	oc or resp	on alony arre	st, strock, c	i ileait		Death
vecuted n and transit	Examiner	if any, leading to immediate cause. Frier Underlying Gauss (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)											
K 68760, a certificate be er ending physiciar use as the burial	Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	AMENDED 23c. If yes, outcom 1 Live birth 4 Pregnant at t wn 9 Unknown	ime of death	2 Fet	tal death ner (Spec	3	Ectopic pre	egnancy		23d. Da Mor	ite of delive	ry Day	Year
P.O. Bes that the degree by the detached	Š	Part II. Other significant condition		but not resultin	ng in the u	nderlying	cause giv	ven in Part I.			provide to	-		e of death?
Division of Vital Records, P.O. Boy ral or Attending Physician: The law requires that the death its after death. al Director: After this certificate has been signed by the attent in the funeral director, page 2 should be detached for	Completed								- [24a. Was a autops perfor	sy med?		completio	dings available on of cause of
	Be C	25. Was case referred to medical examiner?	Henrikalı				10	of Death (Che	eck only					
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	٤	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day Ye Jun 12, 2007	y 28b.	Outpatient Time of Ir 9 hrs	-	8c. Injury	other A Number at Work?		me 5 Describe h ver auto/t	ow injury o		er: Scene	
Division of North to the Hospital or Attending Phywidin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	ation 28e. Place of Inju			et, factory,	office bu	ilding, etc.		Location (S or Town, S I-495 sout	tate)			e Number, City
To the Hospi within 24 hot To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Phys	ician: To the best of my ner:On the basis of exam and manner stated.											s)
	Me	29b. Signature and title of certifier	lectur)			29c	O.C.N					signed (M 3, 2007	onth, Day,	Year)
jÓ		30 Name and address of person what Laron Locke MD. Ass	o completed cause of de istant Medical Exa		1 Penn	Street,	Baltim	ore, MD 2	21201					
	ate	31. Date filed (Month, Day, Year)	32° Registrar		1.	e i								
Registi		JUI U 2 20	or Johnson	OF	RIGINA	2/ L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9, 2 Year 7 **Physician** Month JUNE Thelma Marie Trageser 12:08AM /Medical 4a. Facility Name (*If not institution, give street and number*)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 18, 1 9. Birthplace (State or Foreign **Funeral** Min. Days 1 □ M 2 🗓 F Months Hours 215-03-6415 Maryland 88 1918 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Baltimore Towson 1 □Yes 2 □MVc Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or pe USA 21204 728 Camberley Circle Apt B-2 must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iten Medical Examiner Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) the Office Work Univ. of Md. Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Mary McMahon Harry Trageser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda Barnaba/ Niece 2820 Glen Elyn Way Baldwin, Md. 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 7-2-07 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RESPIRATORY FAILURE burial-trai Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9∏Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy certificate 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director; After the After Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40048 6-29-07

State

the

death with the Maryland

filed within 72 hours after

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

TOWSON.

MARYLAND

21204

7601 OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

32. Registrar's Signature

DAVID BOERSMA

31. Date filed (Month, Day, Year)

		•	1- For State of Maryland /	Department of Health and MacCertificate of Death		ene No 2007	21194
	Physici	an	1. Decedent's Name (First, Middle, Last)	11/200	2. Date of Death Month	Day Year	3. Time of Death
Y	/Medic Examir	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June a	4c. County of Death	P
			Muryland General Hog	oital Baltimore C	rty	NIA	
	Funeral Director		5. Social Secucity Number 6. Sex 7. Age (In yrs. last b	rirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		ace (State or Foreign ry) ピロムロルン
	υ		Usual Residence of Decedent	wn or Location	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		d. Inside Oity Limits
	Maryla -fahov lindal	tor	MD WA	Bootings			1 No 2 No
	ath with the 23a or 28a ust be notifi	Funeral Director	10e. Street and Number 928 Studdard (101. Zip Code 21201		. Citizen of What Count	
5-0036	s 1 and 2 should be filed within 72 hours atter death with the Maryland f Health and Menial Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-f ahow other traumatic event, the Marical Extendible must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Sive Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	an Indian, stc.
15-0	n 72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workir life. DO:NOT use retired)	ng 16	b. Kind of Business/Ind	ustry
2121	filed within Hygiene. other than ont, the Max	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Steel work	er t	tiklatt	+ mital
and	should be filed nd Mental Hygis marked other umatic event, ii	To Be C	17. Father's Name (First, Middle, Last) Thomas Bullo	0/2	ette	Wing	
Mary	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)	8 Grobe Ct 1 Ba	I Route Number, C	City or Town, State, Zip	Code)
ore,	of Heal		20a Method of Disposition 20b. Place		ate 20	c. Location - City or Tov	wn, State
Baltimore	Pag nent int: I		4 Donation 5 Other (Specify)		-07 F	fund als	k, md,
Ba	permit. Departr Imports any Inju		21. Signature Funeral Service License	22. Name and Address of Facility 2	20 Fred	HILTON F	acs uto, md, 2120
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or hear failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac of	r respiratory arresi		Approximate Interval Between
Gara	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	my Artery Di	rall		Onset and Death
,092	cien and burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	Vasinler	Bree	ease	Dykans
P.O. Box 68	that the death certificate I led by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dear 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	ry Day Year
S, P.	The law requires that the ate hes been signed by th bage 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Records,	w require been sig should t				1 🗆 Yes		4.4000
Rec	he law e hes t age 2 s	Completed			24a. Was an autopsy performs	death?	psy findings available inpletion of cause of
Vital	iician: Th certificate rector, pag	BeC	25. Was case referred to medical example?	26. Place of Death		No 1 ☐ Yes	2 No
οť	Physician: r this certifica ral director, p	ဥ	1 ØYes 2 No Hospital: 1 □ Inpatient 2 Ø ER/C		ne 5 Resident	ce 6 ☐Other (Specify)
	Attending I or death. ector: Atter by the funer	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	. Time of Injury at Work? 1 ☐ Yes 2 ☐ No	ess. Bosones nov	mary occurred	
Division	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, streel, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospitel or within 24 hours atte To the Funeral Directional Completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner On the basis of examination and mappier stated.	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cau ad at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of cert lier	29c. License number		l. Date signed (Month, L	
	19		> Ampkan PHP	210P2000 MADIN	+ 1	16/29/2	1007
	7'		30. Name and address of person who controlled cause of death (Item 23a	1) (Type, Print) WASHING	TON P	SLUD RAN	I my 3123
	Sta		31. Date filed (Mpnth, Day, Year) 32. Registrar's Signature				
DH	Regist MH 17 Rev 1/2		JUL 0 2 2007 Keen &	Agree 5			
				DRIĞINAL			

State Registrar gw/n

31. Date filed (Month, Day, Year)

and how

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADNAWAN

AN SINAL
32 Registrar's Signature

6420

Ronald

HOSPITAL

000

OF

2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 8:10 AM **Physician** 41 2000 Minerva LaNeve Zimmerman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🔽 F 87 Oct 16, 1919 Maryland 219-05-0110 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 ☑ No MD Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18641 Carolyn Street 21740 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Clarence Knode Alta Jane Haller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Penny Zimmerman/daughter 18641 Carolyn Street Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ② Donation 5 ☐ Other (Specify) e o Luneral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Final Due to (or a consequence of): disease or condition resulting in death) rie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner lex Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an shop autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be 1 4 Inpatient 2 ER/Outpa 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P

Physician /Medical Examiner law requires that the death certificate be executed sician and burial-tran

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

Funeral

Director

is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division or Vital Records,

physician as the attending p been signed by the should be detached has le 2 , page certificate Hospital or Attending Physician: After this certific funeral director,

25.	Was case examiner?	referred to medical
	1 ☐ Yes	
27.	Manner of	Death

1 Natural

29a. Certifier

28a. Date of Injury investigation

and manner stated.

tient	3 🗆 🛭	OOA	Other:
e of		28c.	Injury at

2 Accident 6 ☐ Could not be determined 3 Suicide 4 ☐ Homicide

5 Pending

(Month, Day Teal)	linary I	М	1 □ Ye
Place of injury - At ho building, etc. (Specif	me, farm, street,	facto	ry, office

28b. Tim

2 □ No	
	28f. Location (Street and Number or Rural Route Number,

Hagerstown ND

28d. Describe how injury occurred

(Check only one) 29b. Signature and title of certifier

1 = ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

mpa	ous, 1	rs _		DG158	8
Name address of perso	n who completed cause of	of death (Item 23a	a) (Type, Print)	retum	87,

29d. Date signed (Month, Day, Year)

Registrar

Certification:

Medical

JUDITH MBKOUA 31. Date filed (Month, Day, Year) JUL 0 2 2007

within 24 hours a er deah.

To the Funeral Director. A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death KINWUMIJU 1314 2007 ONIKE UNE 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death 4c. County of Death BAITIMORE UNVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Secunty Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1□M 2 F Days Hours Min. NIGERIA 38 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1. Yes 2 No PRINCE GEORGE'S MD BLADENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5213 NEWTON STREET # 202 20710 NIGERIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs PN PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GABRIEL A. AKINWUMIJU MERCY A ADEJAYAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OLUFELLA E. AKINWUMIJU/BROTHER 5456 MADISON WAY #11 HYATTSVILLE, MARYLAND 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) MT. OLIVET CEMETERY 6/16/2007 WASHINGTON, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20735 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) POSSIBLE NEUROBIASTOMA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~~ any injury or other traumatic event.

physician and sthe burial-trans

Division or Vital Records, P.O. Box 68760,

		Due to (or as a consequence of):			
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Out to (or as a consequence of):			
dical Exa	resulting in death) Last	C. Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)	23d.	Date of delivery Month Day Year
ed by PI	Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.		contribute to the cause of death?
Complet				24a. Was an autopsy performed? 1 Yes 2 □ No	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Ves 2 □ No
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
To	1 Yes 2 No	Hospital: 1 AInpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hon	ne 5 Residence 6 🗆	Other (Specify)
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury oc	curred
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined		factory, office 2	8f. Location (Street and No City or Town, State)	umber or Rural Route Number,
edical	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 Medical Exam	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause(s) and ed at the time, date and pla	d manner as stated. ace, and due to the cause(s)
ž	29b. Signature and title of certifier		29c. License number	29d. Date si	gned (Month, Day, Year)

State Registrar 22

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flowers

ADRIENNE

31. Date filed (Month,

17401

GREENE ST.

2007

21201

June 3

BATIMORE

	-	State Registrar	ate of Marylar		tificate of			Reg. No.	- 11 1 1	3. Time of Death
Physicia		1. Decedent's Name (First, Middle, Last) WILLIE A	LFORD				Month	Day 20	007 Year	4:27 P
/Medic Examin		4a. Facility Name (If not institution, give street HOLY CROSS HOSPIT			4b. City, Town, C	or Location of Death	1		ounty of Death	
Funeral Director		5. Social Security Number 250-20-6018 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb. 25	y, Year)	9. Birth Con Ber	nplace (State or Forei untry) nnesville,
ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer	_	ty, Town or Loc						10d. Inside City Limi
r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Co	untry?
23a o ust be		3613 Peartree Ct. #	11		20901				d Stat	
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Married	Nas Decedent Ever in U Armed Forces? 1	ĺ	Vas Decedent of life Yes, specify Cub ☐ Yes 2 ☑ Yes 2 ☑ Yes 2	Hispanic Origin? (S pan, Mexican, Puer Specify:	pecity Yes or No to Rican, etc.)		. Race - Amer Black, White pecify: B1a	e, etc.
than "natura be Medical E	Completed	15. Decedent's Educati (Specify only highest grade co		(Give life. L	ent's Usual Occu kind of work done OO NOT use retire	during most of wo	rking		of Business/ Lvate	Industry
Hygie other ent, th		17. Father's Name (First, Middle, Last)		I	CAIL DA		ne (First, Middle			
Aental rked tic ev	To Be	James Alford				Mary M				
ealth and N n 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. James W. Alford /So	n	6805	Brown W	t and Number or R	pper Ma	·1boro	, Md.	20772
nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ™ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	cemetery, crer larmony	sition (Name of natory or other pla Memoria	1 June	Date 15,200	7Lando		4d.
Departr Importa any inju		21. Signature of Funeral Service Censee	M 01085			ess of Facility er S. Por rIboro Pi			Le, Md	
ysician Medical	8	23a. Part . Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ons that caused the dea ause on each line. SEPSIS Due to (or as a conse		er the mode of dy	ring, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death Days
physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate curse. Entail underfining Cause (Disease or injury that initiated events resulting in death) Last	PNEUMONIA Due to (or as a conse							Days
by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnan Other (specify)	icy		23	d. Date of de Month	livery Day Year
signed b	by	Part II. Other significant conditions contributed MYOCARDIAL INFAR		esulting in the u	nderlying cause g	iven in Part I.				o the cause of death robably 4
cate has been signed by the attending I page 2 should be detached for use as	Completed	END STAGE RENAL D	ISEASE				24a. Was auto perl 1∐ Yes		24b. Were a prior to death? 1 ☐ Yes	utopsy findings avail completion of cause s 2 No
h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	pital: 1X Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	f 28c. In	ther: 4 \(\text{Nursing}	Home 5 Res	idence 6		ecify)
3 Suicide 6 Could not be determined building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office City or Town, Screen City or Tow						own, State)				
	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my k r: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred at the nvestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	e cause(s) a e, date and	and manner a place, and du	s stated. le to the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier	Mn			nse number 32332		29d. Date	signed (Mon	2007
61		30. Name and address of person who com	oleted cause of death (It MD 9801 GEO	em 23a) (Type	Print)			-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** P^{M} 2007 Elverda French Ayres 21 2322 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 208 Brown Street E1kton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 7, 1924 7. Age (In yrs. last birthday, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F **Director** 403-24-5436 83 Kentucky Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Maryland Cecil **Elkton** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 208 Brown Street 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Å Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 M Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 end 2 should be filed wit Department of Health and Mr ntal Hygiens Important: If Item 27 is marked other the any lollury or other traumatil event, the once. Program Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. Herbert French Bettie Ruth Pawley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Cecil Street, Chesapeake City, Maryland 21915 Beverly A. Lum/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Aberdeen Proving
Ground Cemetery

22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Pain **Physician** /Medical Due to (or as a consequence of): Examiner Rib Fractives Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical Chronic Obstructur Pulmany Disease IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Tyger Dependen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 A.No O Steakholders 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Private Physician D2635

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division or Vital Records,

EIKEN MD

III West High St. Ste 312

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

T Teal

0 2 2007

Cydray 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Lee Ball, Jr. 8:50 P M June 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Magnolia Nursing Home Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**½** M 2 □ F 76 220-26-4289 Yrs. Director 15, 1930 Maryland Nov. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Yes 2 No Prince George's Lanham Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8200 Good Luck Road 20706 USA death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ XNo Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Maryland 12 ages 1 and 2 should be filed with of Health and Mental Hygie 1: If Item 27 is marked other by or other traumatic event, it. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Lee Ball, Sr. Ivy Mays Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is eny Injury or other trau 12 Silverwood Circle, #5, Annapolis, MD 21403 Anne Cameron - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/14/07 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A.Hyattsville, MD 20781 Dellet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evotic Cardiovascuju Disease **Physician** rears /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending (23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the at Id be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlyigg cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed_ Ac Whites Sacrel 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗔 Natural 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0/852 JUNE 12 2007 completed cause of death (Item 23a) (Type, Print) Dueensburg Rd Hyatkville MISZOZE/ State Registrar

07-04421 Wayne Belisle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease	ype of Pfillt ill black ille	CHOIC HIM			
case	OL 1 - SMandand / Donor	tmont of He	alth and	Mental	Hvaiene
	State of Maryland / Depar	unent of the	saiti and	11101110	, 3

ayne Belisle		- For State	31	ale or ivial	ylariu i	Cert	ificate of	Death					eg. No.			
Physicia		egistrar I. Decedent's Nam	ne (First, Middl	e,Last)							Mo	te of Deat	Day	Year		me of Death 520 hr S
edical Examin	er	Wayne			В	elis	le [b. City, Tow	n or Lo	cation of I		ne 9, 20		ounty of I	Death	
	4	4a. Facility Name University I			nd number)		-	Baltimor		oution of			İ			
	4	5. Social Security		6. Sex	7. Age	(In yrs. la	st birthday)	If Under 1	Year	If Under		ate of Bir	th(MM/DD	YYYY)	Birthplac	e (State or
Funeral Director				1 X M 2		15	Yrs.		Days	Hours	Min.	5/26	/197	1		an Juan
Director		051-84- Usual Residence		1 X M 2	<u> </u>											inidad Inside City Limits
any		10a. State	10b. County			10c. City,	Town or Locati	on								X Yes 2 No
	_	NY	Kings	5		Broo	klyn				11 11 .	17150	10 011-0	of Mino	t Country?	
Aaryland 28a-f show 1 at once.	Director	10e. Street and N	umber					10f. Zip Co	ode			1	rinj Tinj			
th the Maryla 23a or 28a-f notified at on		1298 St	erling	7 Pl.		# 3r		1121 s Decedent	3	amia Origin	n2 / Specify					ndian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh cal Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Mar		12. Wa	s Decedent ned Forces?)	S. 13. Wa	es, specify (Cuban, I	Mexican, I	Puerto Rica	n, etc.)			etc. Bl	
r deati	핆			vorced If Yes, Gi		X No	1	Yes 2 2	₹ No	specify:						dadian
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	à	3 Widowed 15. Decedent's				mpleted)	46a Docoder		cupatio	n (Give k	ind of work	done	16b. Kir	d of Bus	ness/Indus	stry
2 hour "nati	Completed	Elementary/Se			еде (1-4 ог				igilie. L	30 140 1	ase retired;		1		ucti	on
336 thin 7 ne.	힅	12					Paint	er	149	0 Mothor's	s Name (Fir	t Middle			uc c i	
215-0036 be filed within 72 ntal Hygiene. rked other than '		17. Father's Nam		e, Last)	Re	lisl	e			lude			Hors		E	
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	m	Leonaro		ship (Type, Pri		1151	19b. Mailin	g Address	(Street	and Num	ber or Rura	Route No	umber, City	or Town	, State, Zip	Code)# 3r
AD 2 2 should h and M 27 is m amatic	-	Leonar		Belisl	e		1298	Ster	lir	ng P	1 Br	ook	lyn,	NY	112	13 "
		20a. Method of I	Disposition			1	Place of Dispo crematory or o	sition (Name	of cem	etery,	Da	ate			City or Tov	wT
nore ages 1 at of F t: If i		1 X Burial			noval from S		n Juan		1 C	em	06-22	2-07	San	Ju	an T	<u>cinidad</u>
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite	-	4 Donation 21. Signature of	5 Other	e Licensee				Name and A			DIO	okly	n, N	IY.	1121	3
Ba Perm Depu			11/1		Todd	Dre	w Ho	use o	ofH	ills	: 10	ററ ട	St. Jo	bhns	Pl.	Approximate Interv
Physician		23a. Part I. Ente	r the disease,	or complications se on each line.	s that cause	d the deat	n. Do not enter	the mode of	ayıng,	Such as C	al tilac or re-	spiratory	arroot, erre	,		Between Onset an Death
Medical xaminer		Immediate Caus	se (Final disea	se a Multip	ole Injurie (or as a con	S	of):									
		or condition res	uiting in death	b.	(or as a con	sequence	01).									
	er	Sequentially list if any, leading t	o immediate	Due to	(or as a con	sequence	of):									
	Examine	(Disease or inju	ry that initiated	Dun to	(or as a con	sequence	of):	_		-					- 7	
ted	Exa	events resulting	g in death) Las	d.	(0) 00 0 00.	_				_					-	
ox 68760, eath certificate be executed : attending physician and for use as the burial - transit	Medical	UNPEND	DED		NDED											
60, ate be hysici	Med	IF FEMALE:		23c	. If yes, outo	come of pre				Faton	ic pregnanc	· ·	23	Date of Month	f delivery Da	y Year
687 ertifica ding p	l/ue	23b. Was deced past 12 mg	lent pregnant i nths?	n the	Live birth	at time of	=	Fetal death Other (Spec		Ectop	ic pregnanc	у				
Box 687 e death certific the attending p ed for use as the	Physician/	1 Yes 2	No 9		Unknown		•								11 He	- seven of donth?
rds, P.O. B requires that the do been signed by the	4d		ignificant cor	ditions contri	ibuting to de	ath but no	t resulting in th	e underlying	cause	given in F	Part I.					e cause of death? bly 4 Unknov
P.O.	2															psy findings availa
ords, w requir) d												utopsy erformed?	2-5.	prior to co death?	mpletion of cause
COI e law te has	1 5				<u> </u>						_	1 🗸 Y	es 2	10	1 🗸 Yes	2 No
n: Th	ع ا		referred to med	dical					26.Plac		h (Check or		<u> </u>		Other	
Vita ysicia his cel	ď	1 ✓ Yes	2 No	Hospita	al: 1 🗸 Inpa	atient 2	ER/Outpati		DOA	Other ₄		Home 5	ribe how in	ence 6	Other:	
of Vital Recing Physician: The After this certificate					8a. Date of (Month, D: Jun 9, 200	Injury ay,Year)	28b. Time 1432 hrs	· · · · · [ury at Wo	In	river au	uto colli	sion		
ion trendi leath.	1	1 Natura 2 Accide	0	ending			t home, farm, s				nto /	28f. Locati	ion (Street	and Num	ber or Rur	al Route Number,
Division of Vital Records, tal or Attending Physician: The law requin is after death. After this certificate has been is tall to the former of the phent is tall to the former director name of should it.	illied in by the tain.	3 Suicid		Joula not be			e/Express	illeet, lactor	y, ooc	20	F	or To	wn, State) @ Rt. 100	, Glen E	Burnie, Mi	o
D spital hours ineral	6		ide					ccurred at th	e time,	date and	place and c	lue to the	cause(s) a	nd mann	er as state	d.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and the control Directors. After this certificate has been signed by the attending physician and the control of t	ipietei	29a. Certifier (Check only one) 29b. Signature	Medical	Examiner: On t	he basis of	examinatio	n and/or invest	tigation, in m	ny opinio	on, death	occurred at	the time,	date and p		- 2-	
To t with	con	29b. Signature	e and title of ce	anu	manner stat	ieu			c. Licer	nse numb			290	. Date sig	gned (Mor	th, Day, Year)
		(MIOI						0.0	C.M.E.			Ju	ne 10,	2007	
10 (2)		30. Name and	address of pe	rson who comp	leted cause	of death (I	tem 23a)				ID 04004					
1-(3)		Ana Ru	bio MD.	Assistant M	ledical Ex	xaminer	111 Pen	n Street,	Baltin	nore, M	21201 טו					
	Sta	te 31. Date filed	1 8 200	(gar)	32. Reg	istrar's Sig	parti									
Rec	istr	ena JUN	T O CAA	- /4394												

		For State Registrar		State o	i Marylan		artment of F rtificate of i		Mental Hy	/giene Reg. No	200	£ 1	
Dhusisis		1. Decedent's Nar	me (First, Middle	, Last)					2. Date of D Month	eath Da	y Year	3. Time	of Death
Physicia /Medic		Herbe	rt A.	Bates					06	13	2007	945	P M
Examin		4a. Facility Name	(If not institution	, give street and nu	mber)		4b. City, Town, or	r Location of Dea	ath		. County of Deat		
		Sacred	Heart H	ome, Inc.			Hyatts		7.0		Prince G		
Funeral		5. Social Security		6. Sex 1 12 M 2 ☐ F	7. Age (In yrs.	iast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir). (Month, D	ay, Year,	Co	hplace (State ountry)	or Foreign
Director	-	220-26- Usual Residence			100		<u> </u>		Dec.	20, 1	906 VA		
/land		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside	City Limits
Mary Fled	ţo	MD	Princ	e Georges	Hva	ttsvil	1e					1 ★ Ye	s 2□No
r 28g	Director	10e. Street end N		с ссотдес			10f. Zip Code			10g. Ci	tizen of What Co	ountry?	
th wit	alD	5805 Ou	eens Ch	apel Road			20782			USA	1		
ems er mu	Funeral	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Ame Black, Whit		
			rried 2 Marri	ed 1 ☐ Yes If Yes, Gi	2 X No ve		1 ☐ Yes 2 🙀 No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:		
hours ural"	d by	3 ∐ Widowed	4 Divorced	TearorD	ates:			-4'		4.0h 14		Black	
n 72 "nat	Completed			is Education of grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	orking	160. K	(ind of Business	industry	
withii ene. than	щ	Elementary/Sec 12th	condary (0-12)	College (1-4or 5+)		portation			l nc	Governm	ent	
filed Hygi other		17. Father's Name	e (First, Middle,	Last)		Trans	porcacion		ame (First, Middl			СПС	
ld be ental ked c	To Be	Willia	m Bates					Patey	Green				
shou md M mar	۲	19a. Informant's I	Name/Relationsh	nip (Type. Print)		19b. Mailii	ng Address (Street	and Number or I	Rural Route Num	ber, City	or Town, State, J	Zip Code)	
nd 2 alth a 27 Is r trai		Charles	F. Bat	es/Cousin	1	11207	Gunpowde	er Dr. F	t. Washi	ineto	on. MD	20744	
s 1 a		20a. Method of Dis	isposition		20b. F		osition (Name of matory or other place		Date		ocation - City or	Town, State	
Page ent o nt: If ry or			2 □Cremation 5 □ Other (S)	3 □Removal from pecify)	State		emorial	1	2-2007	Suit	land, M	D	
mit. Sortan V Inju		21. Signature of F			JJ III		2. Name and Addre						
an per		P	2 man	Mall	2		4217 9th	. St. N.	.w. Wash	ingto	on, D.C.	20011	
15 61		23a. Part1 Ente	he disease, or	complications that only one cause on e	caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approxim Interval B	ate etween
Physician		Immediate Cause disease or conditi	e (Final		stage r	enal d	isease					Onset and unknow	d Death
/Medical		resulting in death	1)	a	(or as a conseq							UIIKIIOW	11
Examiner		Cognostially list o	onditions	b									
p .±	ner	Sequentially list of if any, leading to it cause. Enter Und	immediate derlying	Due to	(or as a conseq	uence of):							
ificate be executed physician and ts the burial-transit	Examiner	Cause (Disease of that initiated even resulting in death)	nts	с									
oe ex		roodining in docum) Last	Due to	(or as a conseq	uence ot):							
cate o	edical			d	-	 							
		IF FEMALE:		23c If yes ou	tcome pf pregna	ancv					001 Dat 11		
eath certi attending for use a	Sian	23b. Was decede in the past 1	12 months?	1 ☐ Live I	birth 2 Feta	aldeath 3	Ectopic pregnancy Other (specify)	/			23d. Date of de Month	Day	Year
he law requires that the death cert te has reen signed by the attending to ge 2 should be detached for use a	Physician/M	1 ☐ Yes 2 9 ☐ Unknow		9□Unkn		iouiii o L	_ curer (speeny) _						
that led by deta		Part II. Other sign	nificant conditio	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
uires sigr ld be	d by	Conge	stive h	eart fail	ure				1 🗆	Yes 2	. No 3 P	robably 4X	Unknown
s heer	lete								24a. Wa	s an	24b. Were at	utopsy finding	s available
he la e has	Completed								per	opsy formed?	death?	completion of	cause of
an: tiffical tor, p		25. Was case refe	erred to medical					26 Place of D	1∐ Yes eath (Check only	2 K No	o l l∐Yes	2 □ No	
ysick s cer	To Be	examiner? 1 ☐ Yes 25	X No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth		Home 5 ☐ Res		6 □Other (Spe	cify)	
g Ph er thi		27. Manner of Dea		28a. Date		28b. Time o			28d. Describe			<i></i>	
Attending Physician: r death. ector: After this certifica by the funeral director,	atio	1 Matural 2 Accident	5 ☐ Pending investig	jation	iii, Day Teai)	Injury		Yes 2 ☐ No					
r Atte er de; recto by th	titic	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determi	inod 28e. Place	of injury - At he	ome, farm, sti fv)	reet, factory, office		28f. Location	(Street a	nd Number or R	ural Route Nu	ımber,
Ital or rs after all DI led in	Certification:				3, (-,	**							
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, p.ge 2:		29a. Certifier (Check only		g Physician: To the Examiner: On the b									e(S)
To the by within 24	Medical	one)		and man	ner stated.		29c. Licens						
5 <u>vi</u> i 5	<	29b. Signature an	Toylitle of certifier	1	A 1				,		ate signed (Moni		_
		Or	m	Varyy	MI	<u> </u>		5105		リシ	me 14	200	.1
-(10)				who completed cause 3621 Lig				MD 210)42		,	•	
Sta	e	31. Date filed (Mo											
Registra	- 1	JUN 1	8 2007	(in me	Registrar's Signa	sell!							
HMH 17 Pay 1/00	104	,,,,,		1	- /-		· · · · · · · · · · · · · · · · · · ·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland				vientai riy	gierie		
			Registrar		Cei	rtificate of	Death	_	Reg. No.	<u> </u>	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, La	•		01		2. Date of De Month	Day	Year	22:46 M
	/Medic	al	Denise	V	В	cown-On]	Ley r Location of Death	June	11,	2007 ounty of Death	22:40
ž	Examin	er	4a. Facility Name (If not institution, give							nce Ge	eorges
		200	Southern Maryl 5. Social Security Number 6.5	Sex 7. Age (In yrs. In		Clinto	If Under 24 Hrs.	8. Date of Bir	th	9. Birtho	place (State or Foreign
	Funeral Director		214-76-8051	¹ □M ² M F 50	Yrs.	Months Days	Hours Min.	(Month, Da 03/28	7 1 9 5 7	Mary	yland
1			Usual Residence of Decedent				1	<u> </u>			
	rylan show	_	10a. State 10b. County		, Town or Lo					1	10d. Inside City Limits 1X Yes 2 □ No
	e Ma 3a-f s tiffied	5	Maryland Prince	e Georges U	Jpper	Marlbon	0				
	or 2	Ë	10e. Street and Number			10f. Zip Code				n of What Cour	ntry?
	ath v s 23a nust	ra	6109 SW Crain	Highway 12. Was Decedent Ever in U.3	6 40 1	207		nosify Voc or N		USA . Race - Americ	can Indian
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in 0.3 Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	Specify:	o Rican, etc.)		Black, White, pecify: Black	etc.
5	2 hor	ted	15. Decedent's E (Specify only highest gr	Education	16a. Dece	dent's Usual Occup	ation	kina		of Business/In	
<u>'</u>	thin 7 e. an "r Med	ed t	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. i	DO NOT use retire	d) -	-			Therapy & Center
7	ed wil	Completed	12		Chi	ropract			1		Center
and	ild be filed lental Hyg ked other ic event, i	Be (17. Father's Name (First, Middle, Las	_	_		18. Mother's Nar	ne (First, Middle			inkney
<u>X</u>	should and Men s marke umatic	은	Michael	L	Brov		Gloria	15	E		
12	12 sho hand 7 Ismu		19a. Informant's Name/Relationship		1						Code)20772
a	1 and Health em 27 ther tr		Curtis Onley S 20a. Method of Disposition			SW Cras osition (Name of matory or other pla		Date		tion - City or To	Maryland own, State
100	Pages nent of int: If its iry or o		1X Burial 2 □Cremation 3 [4 □Donation 5 □Other (Speci	Hemoval from State		matory or other pla Episcor	1	1/07	Unne	r Marl	Marylan
Saitimor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	ensee	22	2. Name and Addre	ess of Facility A	dams F	unera	1 Home	e PA
	HD = 60		23a. Part1. Enter the disease, or our shock, or hear failure. List only	nplications that caused the death	h. Do not en	U6U5 AQ1 ter the mode of dvi	na. such as cardia	or respiratory	asco,	Mar yra	and 20608 Approximate
and a	Physician		shock, or hear failure. List only Immediate Cause (Final disease or condition	y one cause on each line.		21.0	- 4	1 .			Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	The Welas	taxes	to lu	450	nd Nea	7
	/Medical Examiner	.	resulting in death)	Congestre	is,	4 Welan	taxio	to hu	egs a	nd Nea	7
2'	Examiner	niner	resulting in death)	Due to (or as a consequence of the consequence of t	is,	Heari	Taxos 9-7a	to lui	45 a	nd Nea	7
٦,	Examiner	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Congestre	uence of):	Heari	Tain g	to lu	4	ad Nea	7
,00,	Examiner	cal Examiner	resulting in death)	Duylo (or as a consequence.	uence of):	Heari	Taxing Tax	to less	4	ad Nea	7
68/60,	Examiner	dical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Duylo (or as a consequence.	uence of):	4 Webs	Taxio	to lui	950	nd Nea	7
BOX 6	aath certificate be executed as attending physician and for use as the burial-fransit	dical	resulting in death)	Duylo (or as a consequence.	uence of): uence of): ancy il death 3[Webs. Wessi		to lui		d. Date of delive Month	7
P.O. BOX 6	aath certificate be executed as attending physician and for use as the burial-fransit	Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[□Ectopic pregnanc □ Other (specify) _	у	to lui	23	d. Date of deliv	rery
P.O. BOX 6	aath certificate be executed as attending physician and for use as the burial-fransit	by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[□Ectopic pregnanc □ Other (specify) _	у	Yu lun	23	d. Date of deliv	very Day Year
P.O. BOX 6	aath certificate be executed as attending physician and for use as the burial-fransit	by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[□Ectopic pregnanc □ Other (specify) _	у	23e. Did	23 tobacco use Yes 2□	d. Date of delive Month de contribute to the No 3 Pro 24b. Were aut	the cause of death? bably 4 Unknown
Hecords, P.O. Box 6	aath certificate be executed as attending physician and for use as the burial-fransit	by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[□Ectopic pregnanc □ Other (specify) _	у	23e. Did 1 = 24a. Was aut	tobacco use Yes 2 s an ppsy ormed?	d. Date of delive Month Solution of the Control of	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
Hecords, P.O. Box 6	The law requires that the death certificate be executed to the has been signed by the attending physician and mage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[□Ectopic pregnanc □ Other (specify) _	у	23e. Did 1 = 24a. War aute per 1 = Yes	tobacco use Yes 2 s an spsy ormed? 2 No	d. Date of delive Month e contribute to the Second Processing Sec	rery Day Year the cause of death? bably 4 Unknown opsy findings available
Vital Records, P.O. Box 6	The law requires that the death certificate be executed to the has been signed by the attending physician and mage 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): ancy il death 3[leath 5[leath 5[leath 5]]	□Ectopic pregnanc □ Other (specify) □	y ven in Part I. 26. Place of De	23e. Did 1 = 24a. War aute per 1 = Yes	tobacco use Yes 2 s an ppsy ormed? 2 No one)	d. Date of delive Month e contribute to the con	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
or Vital Records, P.O. Box o	nystclan: The law requires that the death certificate be executed by the attending physician and mis certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a consequence) C. Due to (or as a consequence) d. 23c. If yes, outcome pf pregnant 1	uence of): uence of): ancy al death 3[eath 5[uulting in the u	□Ectopic pregnanc □ Other (specify) □ inderlying cause given	y ven in Part I. 26. Place of Dener: 4 □ Nursing H	23e. Did 1 24a. War autre per 1 1 Yes ath (Check only)	tobacco use Yes 2 s an ppsy ormed? 2 No one)	d. Date of delive Month e contribute to the con	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
or Vital Records, P.O. Box o	nystclan: The law requires that the death certificate be executed by the attending physician and mis certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) C. Due to (or as a consequence) d. 23c. If yes, outcome pf pregna 1	uence of): uence of): uence of): uence of): ulting in the u ulting in the u ER/Outpatiet 28b. Time of Injury	□Ectopic pregnanc □ Other (specify) □ underlying cause given nt 3□ DOA Other 28c. Inju Wo M 1□	yen in Part I. 26. Place of Dener: 4 \(\text{Nursing } \) horself rk? Yes 2 \(\text{No} \)	23e. Did 1 □ 24a. War aut per 1 □ Yes ath (Check only Home 5 □ Res 28d. Describe	tobacco use Yes 2 s an opsy ormed? 2 No one) sidence 6 how injury	d. Date of delive Month de contribute to 1 No 3 Pro 24b. Were autorior to contribute to 1 Pro 10 Yes Other (Specioccurred	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 \sum No
Vital Records, P.O. Box 6	nystclan: The law requires that the death certificate be executed by the attending physician and mis certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 15 Yes 2 No 27. Manner of Death	Due to (or as a consequence) c	uence of): uence of): uence of): uence of): ancy il death 3E eath 5E ulting in the u ER/Outpatiel 28b. Time of Injury ome, farm, st	□Ectopic pregnanc □ Other (specify) □ underlying cause given nt 3□ DOA Other 28c. Inju Wo M 1□	yen in Part I. 26. Place of Dener: 4 \(\text{Nursing } \) horself rk? Yes 2 \(\text{No} \)	23e. Did 1 24a. Waa auto per 1 1 Yes ath (Check only) dome 5 Res 28d. Describe	tobacco use Yes 2 s an opsy ormed? 2 No one) sidence 6 how injury	d. Date of delive Month de contribute to 1 No 3 Pro 24b. Were autorior to contribute to 1 Pro 10 Yes Other (Specioccurred	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
or Vital Records, P.O. Box o	nystclan: The law requires that the death certificate be executed by the attending physician and mis certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 15 Yes 2 No 27. Manner of Death 28 No No 27. Manner of Death 29 Accident No No 29 Certifier 18 Certifying Females.	Due to (or as a consequence of the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to death but not rest to the contribution to the contr	uence of): uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatience of the properties of	□Ectopic pregnanc □Other (specify) □ Inderlying cause given Int 3□DOA Other Off 28c. Inju Wo M 1□ Treet, factory, office th occurred at the temperature of the second of the secon	y ven in Part I. 26. Place of Dener: 4 \(\text{Nursing Herry at rk?} \) Yes 2 \(\text{No} \) No ime, date and place	23e. Did 1 24a. Wa: aut per 1 Yes ath (Check only conditions) 28d. Describe 28f. Location City or To	tobacco use Yes 2 s an opsy ormed? Thou one) sidence 6 how injury (Street and own, State) e cause(s) a	d. Date of deliv Month e contribute to 1 No 3 Pro 24b. Were aut prior to cc death? 1 Yes Other (Specioccurred	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number,
or Vital Records, P.O. Box o	The law requires that the death certificate be executed to the has been signed by the attending physician and mage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) C. Due to (or as a consequence) d. 23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of described by the second b	uence of): uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatience of the properties of	□Ectopic pregnanc □Other (specify) □ Int 3□DOA Other Int 3□DOA Other Int 3□DOA other In	y yen in Part I. 26. Place of De. her: 4 \(\triangle \) Nursing H ry at rt? Yes 2 \(\triangle \) No ime, date and plac opinion, death occ se number	23e. Did 1 24a. Waa autre per 1 1	tobacco use Yes 2 s an ppsy ormed? 2 No one) idence 6 how injury (Street and own, State) e cause(s) a e, date and p	d. Date of delive Month e contribute to the con	the cause of death? the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 In No ify) rai Route Number, stated, to the cause(s) Day, Year)
or Vital Records, P.O. Box o	nystclan: The law requires that the death certificate be executed by the attending physician and mis certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of the contributing to death but not result of the contributing to the best of my known and manner stated.	uence of): uence	□Ectopic pregnanc □Other (specify) □ Int 3□DOA Other Int 3□DOA Other Int 3□DOA other In	y yen in Part I. 26. Place of De. her: 4 \(\triangle \) Nursing H ry at rt? Yes 2 \(\triangle \) No ime, date and plac opinion, death occ se number	23e. Did 1 24a. Waa autre per 1 1	tobacco use Yes 2 s an ppsy ormed? 2 No one) idence 6 how injury (Street and own, State) e cause(s) a e, date and p	d. Date of delive Month e contribute to the con	the cause of death? the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 In No ify) rai Route Number, stated, to the cause(s) Day, Year)
or Vital Records, P.O. Box o	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and the statement of th	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of the contribution of the basis of examinar and manner stated. Due to (or as a consequence of the contribution of th	uence of): uence	Document at the threstigation, in my	yen in Part I. 26. Place of Dener: 4 \(\text{Nursing In Record} \) very at the second opinion, death occording the second opinion, death occording the second opinion.	23e. Did 1 24a. Waa autre per 1 1	tobacco use Yes 2 s an ppsy ormed? 2 No one) idence 6 how injury (Street and own, State) e cause(s) a e, date and p	d. Date of delive Month e contribute to the con	the cause of death? the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 In No ify) rai Route Number, stated, to the cause(s) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 200 Helen Hopkins Ball /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year Days 1 ☐ M 2 🕱 F Maryland 219-18-0475 June 18. Director Usual Residence of Decedent 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location a or 28a-f show t be notified at 10h. County 1 ☐Yes 2 X No Director Havre de Grace Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a (Examiner must b U.S.A. 21078 Funeral 3806 Rock Run Rd Race - American Indian . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 "natural", or Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4or 5+) Payroll Technician Government is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Rigdon ၉ Noble Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is 3806 Rock Run Rd. Havre de Grace, MD 21078 Harold F. Ball (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State injury or 06/20/2007 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Garden's Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Mitchell Smith Funeral Home 123 S. Washington St. Havre de Grace, MD 21078 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final merromsalm Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner patutens, or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine The law requires that the death certificate be executed attending physician and Records, P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 Probably 4 Unknown Completed ,24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∏ Yes Vita or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 4 Nursing Home 2 No 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 □ ER/Outpatient Certification: To ō Director: After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 person who completed cause of death (Item 23a) (Type, Print) 410 Mh6 31. Date filed (Mor State UN 18 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend ItemState per attlange 69,007/02/07/11Health and Mental Hygiene For State Registrar Item 26 per verb Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 1:30^p ^M ARL DIK 2007 24. May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 89 Yrs. July 20, 1917 Virginia Director 225-01-0308 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🙀 No MD Anne Arundel Pasadena Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 601 Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify. 3altimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Meat Cutter Food Store 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be 1 Mental I Rose Kayser Charles Edward Dill ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lepartment of Health at Important; if Item 27 Is n any Injury or other trees. A Street, Pasadena, MD 21122 Rose Waldron/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Highland Burial Park 05/28/2007 Danville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Swicegood Funeral Home, Inc. 21. Signature of Funeral Service Licensee 564 W. Main St., Danville, VA Karen Brendle Per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical o (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician use as t attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 PERTENSION 3 ☐ Probably 4 ☐ Unknown 1 Yes 2[*No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has I page 2 s autopsy performe 1□ Yes 24 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 10 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 6 Wotner (Specify) Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

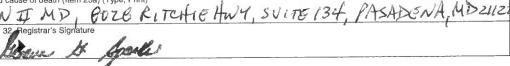
the Funeral Director: A pupletely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 121336 0

State Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)



completed cause of death (Item 23a) (Type, Print)

MD

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death P 1. Decedent's Name (First, Middle, Last) **Physician** 11:18 M Dolores Maryann Curley 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Lorien Nursing Home Airy Carroll 9. Birthplace (State or Foreign 1932 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 24, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 🔣 75 215-28-3823 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , or Items 23a or 28a-f show the Medical Exercities must be nutitied at 1 ☐ Yes 2X No Director Md Carroll Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4612 Ridge Road 21771 United States Funeral death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes **X**☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3€Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12th \end{array}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 Is marked other tim any injury or other traumatic over Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Casimir Novak Anna Kasgmarowski ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Curley Daughter 4612 Ridge Road Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 14 ☐ Donation 5 Other (Specify) Highview Mem. Gardens June 15, 2007 Fallston, MD 22. Name and Address of Facility 21. Signature of Service Licensee Burrier-Oreen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Approximate Interval Between Onset and Death Pnysician 109 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enier Universing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medicai the as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 📉 No After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural 2 Accident death. 1 Tyes investigation after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO

State Registrar

JUN 1 4 2007 DHMH 17 Rev 1/2001

Willser

31. Date filed (Month, Day, Year)

Kus

ORIGINAL

Stoner

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

307

Physicia /Medic Examin

Funeral Director

•	For State Registrar	Ceri	tificate of E	Death	Re	g. No.		
% .	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
ın al	Scott Michael Cr	awford			June 1	6, 200	7	7:59 A M
er	4a. Facility Name (If not institution, give street and number		4b. City, Town, or			4c. County		
	7083-B Jasper Drive	(Late late land	Middlet If Under 1 Year	OWN If Under 24 Hrs.	8. Date of Birth	Fre	deric	.K place (State or Foreign
	159-54-6132 1□M 2□F	ge (In yrs. last birthday) 33 Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 8,	^{Year)} 1973	Coui	rland
	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Loc	cation				1	10d. Inside City Limits
tor	Maryland Frederick	Middleto	own					1 ☐ Yes 2 No
Direc	10e. Street and Number 7083-B Jasper Drive		10f. Zip Code 2176	g	1	0g. Citizen of U.S.A		ntry?
erai	11. Was Deceden	Ever in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Ra	ice - Ameri	
Be Completed by Funeral Director	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Dates	ANO 1	fYes, specify Cuba I□Yes 2⊠No	n, Mexican, Puerto Specify:	o Rican, etc.)	Speci	ack, White, ify: Wh	etc. nite
ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation Juring most of work		16b. Kind of E	3usiness/In	ndustry
nple	Elementary/Secondary (0-12) College (1-4or	5.1\	kind of work done of DO NOT use retired ner/0pera			Trucki	ng Cc	mpany
Con	17. Father's Name (First, Middle, Last)	Ow1	ner/opera		ne (First, Middle, i			
) Be	James Edward Crawfo	rd		Kathr	yn Mar1	ene St	ahr	
P_	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a					p Code)
	James J. Crawford - Broth	er 2484	4 Woodfie	ld Road,				
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Penation 5 ☐ Other (Specify)	20b. Place of Dispose cemetery, crem Metropol:	natoni or other plac	atorium		20c. Location Alexan		own, State Virginia
:	21. Signature of Funeral Service Doenses	m 22	Name and Address Name Address N	ss of Facility -William e Road,	s P.A. Damascu	Funera s, Mar	1 Hom	le 20872
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between
		hot Wound o:	f the Hea	.d				Onset and Death Minutes
	regulting in death)	s a consequence of):		· ·				
_	Sequentially list conditions, bb.	as a consequence of):						
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o a concoquence on.						
Aedical Examiner	resulting in death) Last C. Due to (or a	s a consequence of):						
ical								
Med	IF FEMALE:							
Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	⊒Ectopic pregnancy □ Other (specify)	/			Date of deli Month	very Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown							
y P	Part II. Other significant conditions contributing to death	but not resulting in the u	ınderlying cause giv	en in Part I.				the cause of death?
ed k	Depression				1 🗆 \			obably 4 □Unknown
nplet					24a. Was autop	an 24l osy rmed?	b. Were au prior to death?	topsy findings available completion of cause of
					1□ Yes	2 X No	1 🗆 Yes	2 No
Be	25. Was case referred to medical examiner? 1/X Yes 2 No Hospital: 1 Inp.	atient 2 ER/Outpatie	at 3 DOA Oth	or	ath <i>(Check only o</i> Home 5 K Resid		Other (Sna	cifu)
5.	27 Manner of Death 28a, Date of I	niury 28b. Time o	of 28c, Inju		28d. Describe			сну)
atior	1 □ Natural 5 □ Pending (Month, 2 □ Accident investigation 06/16/2		A M 1 □	Yes 2 XNo	1	t Shot		
tifica	3 X Suicide 6 ☐ Could not be determined 28e. Place of building,	injury - At home, farm, st etc. <i>(Specify)</i> At Home	reet, factory, office		28f. Location (S City or Tox	Street and Nu vn, State)	7083-1	ural Boute Number, B Jasper Dr.
Cer					Middle	town,	Mary1	Land
Medical Certification:	29a. Certifier 1 ☐ Certifying Physician: To the be (Check only one) 2 ☑ Medical Examiner: On the basing and manner	s of examination and/or ir	nvestigation, in my	opinion, death occ	curred at the time,	date and plac	e, and due	e to the cause(s)
Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig		
	1 Com Kalison N	D DMI	= D371	.97		June	18, 2	2007
	30. Name and address of person who completed cause of							
	Alan Rohrer, M.D. D.M. 31. Date filed (Month, Day, Year) 32. 199		t Seventh	Street,	Freder	ick, M	aryla	and 21701
ate trar	JUN 1 9 2007	istrar's Signature	book					

St

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 4 Day 2007 JUNEⁿ **Physician** 3:15 P M CAIN MARY LOUISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BOWIE MARYLAND PRINCE GEORGE 9906 BALD HILL ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT • 20 • 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** VIRGINIA 1□M 2ĂF 230-14-2488 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits ahow. 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic avant, tre Medical Examinar must be notified at BOWIE MARYLAND 1 ☐ Yes 2 No MARYLAND PRINCE GEORGE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9906 BALD HILL ROAD 20721 $U \cdot S \cdot A \cdot$ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or itler any injury or other traumatic avant, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complete Elementary/Secondary (0-12) College (1-4or 5+) NURSE AIDE HEALTH CARE 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT NORRIS, SR. ONIE WIGGINS NORRIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY CAIN HEMBRY (DAUGHTER) 9906 BALD HILL ROAD BOWIE MARYLAND 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State MT.OLIVE CHURCH 6/9/07 WICOMICO CHURCH VA. 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY O. WADDY P.O. BOX 305 Wat 6784 MARY BALL ROAD LANCASTER VA. 22503 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final CARCINOMA COLORECTAL Physician disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physicien and use as the buriat-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown plnods Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes Division of Vital al or Attending Physician: T s after death. al Director: After this certificat ad in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13594 cur/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3060 MITCHELLVILLE ROAD BOWIE MARYLAND 20716 NORMAN MCKOY M.D. 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

	1 - For State Registrar	State of M	aryland / Depa	artment of F rtificate of a			ene g. No.	an Price 1
hysician /Medical	Decedent's Name (First, Middle, Last ISABELLA	•	TE CORNELL			2. Date of Death Month APR 2	Day Yea 26 2007	3. Time of Death 10:24 P
Examiner	4a. Facility Name (If not institution, give			4b. City, Town, o		ath	4c. County of De	
	NATIONAL NAVAL 1 5. Social Security Number 6. S		NTER e (In yrs. last birthday)	BETH If Under 1 Year	ESDA If Under 24 Hi	re la Data d'Allah	MONTG	
ineral rector		□ M 2X1F	Yrs.	Months Days	Hours Mi	n. (Month, Day,	2007	linthplace (State or Foreig Country) MARYLAND
is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at TO Be Completed by Funeral Director	10a. State 10b. County	COLIMBIA	10c. City, Town or Lo	cation				10d. Inside City Limit
tor 28a-f si	10e. Street and Number	COLUMBIA		10f. Zip Code		10	Og. Citizen of What	
Sa or	1584C EGLIN WAY	APT C		2003	2		UNITED S	•
cinermunt	11. Marital Status	12. Was Decedent	Ever in U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race - Ar	nerican Indian,
by Fur	3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No	f Yes, specify Cuba 1 □ Yes 2 🛣 No		erto Rican, etc.)	Specify:	nite, etc. BLACK
Completed	15. Decedent's Ec (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occup	during most of w	orking 1	6b. Kind of Busines	ss/Industry
mp	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	0			
ပိ	0 17. Father's Name (First, Middle, Last)			N/A	18. Mother's N	ame (First, Middle, M	faiden Sumame)	
To B		CORNELL				CIA DENISE	,	
To	19a. Informant's Name/Relationship (MARCIA D. EVANS)			g Address (Street		Rural Route Number,		, <i>Zip</i> Co <i>d</i> e)
	20a. Method of Disposition 1 Burial 2 Cremation 3	4.50	20b. Place of Dispo			Date 2	Oc. Location - City of	or Town, State
	4 ☑ Donation 5 ☐ Other (Specify)	STOT MAMC 1	Sethesto F	20 12/	une 07 B	ettesta Mi	
ODCE.	21. Signature of Funeral Service Ticen	see				Visconsin Av	in Betherde	MD
n al	23a Pan1. Enter the disease, or comushock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	the death. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с.	a dor sequence of):					
dical Ex	resulting in deathy Last	Due to (or as	a consequence of):					
Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ◯XNo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
þ	Part II. Other significant conditions co	entributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
eted						1 🗍 Yes	s 2 X □No 3□1	Probably 4 □Unknowr
Completed						24a. Was an autopsy perform	ed? prior to	autopsy findings available completion of cause of 2 XNo
Be	25. Was case referred to medical examiner?	Hospital:		Othe		eath Check only one		
<u>اد</u>	1 ☐ Yes 2 💢 No 27. Manner of Death	1 LX inpatie			4 🗆 Mursing	Home 5 Residen		pecify)
ertification;	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Day	Year) Injury	28c. Injury Work	res 2 □ No	28d. Describe how	w injury occurred	
Certif	4 Homicide determined	28e. Place of Inju	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or i State)	Rural Route Number,
Medical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsicien: To the best iner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the timestigation, in my op	e, date and place pinion, death occ	ce, and due to the cau	use(s) and manner at and di	as stated. ue to the cause(s)
M	29b. Signature and title of certifier	1 -		29c. License			d. Date signed (Mor	nth, Day, Year)
	1 Cim	horn	-mo.	MD 25	5592 (AI	')	4/30/	07
	30. Name and ddress of person who of JIBKI N. WIGGINS	14.370	eath (Item 23a) (Type, I ISN	Print)		IONAL NAVA		
State	JIBKI N. WIGGINS 31. Date filed (Month, Day, Year) 21	- 100	JSN ar's Signature	W. S. J	BETH	IESDA MD 2	0889-5600	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 5:00 ам 14, June Ducey Frances Ann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3301 Estelle Terrace Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours 28, Feb. 1926 Washington, 579-34-3740 81 DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3301 Estelle Terrace 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specif White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Albert Engler Angela Ginechesi ို 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any Injury or other tra David Francis Ducey, Jr./Husband 3301 Estelle Terrace, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 18 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2007 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. Kehard I Hales 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 Months disease or condition resulting in death) a Carcinona of the Pancreas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has the funeral director, page 2 s autopsy performe 1☐ Yes 2½ No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home SX☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2k No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1K Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide K3xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 24 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier D02338 June 15, 2007 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

10

State Registrar Year)

2007

Richard Delaney, M.D. 3929 Ferrara Drive, Silver Spring, MD 20906 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death OIOI 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Catherine 11:44 A^M 2007 Adams Daly June 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8101 Connecticut Ave. #405-South Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 94 Director 123-09-4567 May 14, 1913 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Montgomery Chevy Chase 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? death with # 405- South 20815 8101 Connecticut Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes **XX**No à Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles Edward Adams Catherine A. Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Dundee DR. Chevy Chase, Md 20815 Catherine L. Daly / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State d 4 □ Donation 5 □ Other (Specify) Heaven June 15, 07 Silver Spring, Md 22. Name and Address of Facility Joseph Gawler's Sons Inc. Gate Of Heaven 21. Signature of Funeral Service License W ill 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): JME Examiner Spinal Fracture Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Fall burial-trar and Due to (or as a consequence of): Ø Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1∐ Yes 2X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SPResidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 501/12 Kirchen Jun 11 2007 2X Accident 1 ☐ Yes 2 No एहरी 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At hom building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Home Chase

10

29a, Certifier (Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael J. Grady MD

JUN 1 8 2007

DHMH 17 Rev 1/2001

State Registrar 1 🗵 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0038781

4201 Cathedral Ave. NW Washington DC 20016

mo 20815

29d. Date signed (Month, Day, Year)

JUne 13, 2007

Kouy

		1 - For State Registrar	State of Maryland		artment of H		d Mental Hy	giene Rag. No	17	21211
		Decedent's Name (First, Middle, Last)					2. Date of De		V	3. Time of Death
Physici		Charlie Pleas	ant Davis, Jr				June	Day 2	Year 2007	4:00A M
/Medio Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of [Death	4c. Count	y of Death	
		Forest Glen Nu	sing & Rehab.		Sil	ver Sp		1	Montgo	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Id		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)	9. Birthp Coul	place (State or Foreign ntry)
Director		579-68-0510	59	Yrs.			Oct. 2	5, 1947	Wasl	n., DC
pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					I0d. Inside City Limits
Aaryli 1 sho	ō		,				• 1 1			1 No Yes 2 No
the N 28a-	Director	Maryland Prince Ge	eorge's		10f. Zip Code	yattsv	тте	10g. Citizen of	What Cou	ntry?
with se or		3802 Thornwo	and Pond		,	2078	4	Unii	ted Si	tates
leath ms 23	Funeral		12. Was Decedent Ever in U.	S. 13. y	Was Decedent of H		n? (Specify Yes or N Puerto Rican, etc.)		ce - Ameri	can Indian,
r Her o	F	1 ☐ Never Married 2 🔯 Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give				Puerto Rican, etc.)		ack, White,	
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spec	ity:	Black
72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation (campleted)	16a. Deced	dent's Usual Occup	ation during most o	f working	16b. Kind of	Business/In	dustry
thin thin	gu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)				
ed wi	ပ္ပ		$2\frac{1}{2}$		<u>Federal P</u>			-	Gover	nment
De fil doth	Be	17. Father's Name (First, Middle, Last)				18. Mothers	Name (First, Middle			
Y Could Men Men Marks	ပို		sant Davis, Sr					Mae Smi		- Code)
ine; Infally lated Z 1.Z 1.3-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at	1	19a. Informant's Name/Relationship (Ty Wonder Moore-Da		1			or Rural Route Numb oad, Hyat			20784
Daltilliore, We permit. Pages 1 and 2 Department of Health a Important: If them 27 is any Injury or other tree once.		20a, Method of Disposition	20b. P	ace of Dispo	sition (Name of	1	Date	20c. Location		
2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	emetery, crer	natory or other place	I				
mit. Pages partment of portant: If II y Injury or co.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signathre of Füneral Service License	11.		The state of the s		6/15/2007 Stewart			am, MD
Dermi permi Depare Impo		21. Signature of Pureral Service Licens	town to	, ,			g Rd., NE			20019
		23a, Part1. Enter the disease, or compli	ications that caused the death	. Do not ent					, 20	Approximate Interval Between
Physician / Medical Examine percented physician end physician end the pruial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A. Respirat Due to (or as a consequence) Stroke Due to (or as a consequence) Due to (or as a consequence)	ience of):	rest					
I NECOLUS, T.O. DOX OX The law requires that the death certificate has been signed by the ettending plage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,			ate of deliv	ery Day Year
wrequires that been signed b	Þ	Part II. Other significant conditions con Hyperte		ulting in the u	nderlying cause giv	en in Part I.	1	tobacco use co Yes 2□No		the cause of death?
¥ rec	Completed	Diabete	s Mellitus-II				24a. Wa	s an 24b	. Were aut	opsy findings available ompletion of cause of
ON OI VICAI MEGing Projection: The lay h. After this certificate has funeral director, page 2	E						— aut per 1 ☐ Yes	opsy formed? 2K No	death?	
En: 1	0	25. Was case referred to medical				26. Place o	f Death (Check only		103	20,10
ysici ysici is cer direct	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital:	ER/Outpatier	nt 3 DOA Oth	05	ing Home 5 ☐ Re		ther (Speci	fy)
g Phy erthic		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at	28d. Describe	how injury occ	urred	
SION ttandin Jeath. tor: Aft the fur	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Bay roat)	,,		Yes 2□No				
UNISION tal or Attending s after death. al Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location City or To	(Street and Num own, State)	nber or Rui	al Route Number,
UNISION OF VICA To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.		vestigation, in my o	pinion, death		, date and place	e, and due	to the cause(s)
With To t	Σ	29b. Signature and title of certifier	1		29c. Licens			29d. Date sign		
		> yours	i sult	enp		D56691		Jι	ine 13	3, 2007
(2)		30. Name and address of person who co				_				
1/2/		Ghousia Sulta	ana, M.D. 121		ritage Pa	rk Cir	cle, Silv	er Spri	ng, M	20906
St Regist	ate	31. Date filed (Month, Day, Year)	Sz. Megistrar's Signa	in the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	1	For State Registrar	State of Ma	ryland / Depa	artment of H rtificate of L			ene 007	21215
Physician /Medical	1	I. Decedent's Name <i>(First, Middle, Last</i>	Girl	DLOL	1HY		2. Date of Death Month	Day Year	
Examiner	ď	a. Facility Name (If not institution, give SHADY GROVE AD	street and number)	HOSPITAL	4b. City, Town, or	VILLE, N.	luntGomery	4c. County of De	
Funeral Director		NUNC	x 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	9. 8 2007	inthplace (State or Foreigr Country) MARYLAM
or 28a-f show		Jsual Residence of Decedent 10a. State 10b. County FREDER	ick	10c. City, Town or Lo	cation	RYLAN	r D		10d. Inside City Limits 1 ✓ Yes 2 □ No
iffer death with the Mar ir Items 23s or 28s-f si ir er must be rediffed Funeral Director		10e. Street and Number 48 HAMILTON	J AVEN		10f. Zip Code	31701		g. Citizen of What C	Country?
n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cdical Examinat must be notified at leted by Funeral Director	oy ruilei	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 Yes (Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 20 No	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
ed within 72 hourygiene. Ner than "natura It, the Medical E	ווייייייייייייייייייייייייייייייייייייי	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work)	ing	ط 6b. Kind of Busines	s/Industry
should be filed within and Mental Hygiene. marked other than "matic event, the Me	מ	17. Father's Name (First, Middle, Last)	<i>Q</i>			_ <u>'</u>	e (First, Middle, M.	aiden Sumame)	,
1 and 2 : Health ar em 27 is ther trau		19a. Informant's Name/Relationship (7) SABRINA DLOUH 20a. Method of Disposition	Y/MOTHE	R 48	AMLZ AMLZ sition (Name of matory or other place	ON AVE	ENUE, FI	REDERICA Oc. Location - City of	C MS 2170 or Town, State
permit. Pages Department of I Important: If its any injury or o once.		1 Burial 2 Cremation 3 5 4 Donation 5 Other (Specify, 21. Signature of Fundral Service Licens	<u> </u>	STERI	CYCLE 2. Name and Addres GAH. 996	s of Facility		- 55	VER, NC ROCKVILLE,1
ificate be executed g physician and as the burial-transit edical Examiner	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.	the death. Do not entered a consequence of): a consequence of):	er the mode of dying	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death
The law requires that the death certificate be the has been signed by the attending physicizage 2 should be detached for use as the but completed by Physician/Medical	yardanimedica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
quires that an signed by uld be deta	בֿר ב	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	pt.	to the cause of death? Probably 4 Unknown
	Total L						24a. Was an autopsy performs	prior to	
ysician s certifii director	ב	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital: 1 XInpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA Othe	r	n <i>(Check only one)</i> me 5 ☐ Residen) ice 6 □Other (Sp	ecify)
tal or Attending Ph. ss after death. al Director: After thi ed in by the funeral. Certification: T		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	Work	at ? 'es 2 🗆 No	28d. Describe how	v injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter complately filled in by the funeral Director Atter Management of the funeral Medical Certification		3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	iry - At home, farm, sti . (Specify)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
thin 24 hour thin 24 hour the Funer ompletely fill	200	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sicien: To the best of ner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cau red at the time, dat	use(s) and manner te and place, and di	as stated. ue to the cause(s)
O IV		29b. Signature and title of certifier	on, while		DO05			d. Date signed (Moi	
State		30. Name and address of person who con KACPANA HELM (31. Date filed (Month, Day, Year)	ompleted cause of de BRECTH, Registra	eath (Item 23a) (Type, 9901 MED	Print) PICAL CENT	ER DR, R	CXXVILL	e Maryl	2007 LAND 20850

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:05 PM Clarance East June 14, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Southern maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral Months Days 1 XM 2 F 246-88-3090 55 3, 1952 North Carolina Director June Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

The state of the stat 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director Maryland | Prince George's Cheltenham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10407 Blackstone Avenue 20623 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 2 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Superintendant Private other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event Be Dewey F. East Bonnie Barber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan H. East (Wife) 10407 Blackstone Avenue, Cheltenham MD 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Ft. Lincoln Cemetery 6/19/2007 Brentwood, Maryland 4 ☐ Donation 5 Other (Specify) unera 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signatur of Service License 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ediate Cause (Fin-L **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No death? 2□No 25. Was case referre examiner? 1∐ Yes 26. Place of Death (Check only one) Be director 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To this filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Hospital or Attending 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and addras of person who completed cause of death (Item

Registrar DHMH 17 Bev 1/2001

State

31. Date filed (Month, Day, Yea
JUN 1 8 2007

JUN 18

32. Registrar's Signa

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:07 A James Kenneth 16, 2007 <u>June</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 28, 19 If Under 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Months Director 212-48-8531 60 1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "neturel", or Items 23e or 28e-f shovidical Examiner must be notified at 1XXYes 2 No Frederick Maryland Frederick Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 USA 200 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes, Give White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Mudical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Construction/Repair Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flohr Virginia Elsie Lamm Monroe 2 Kenneth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick,MD 21701 200 Maple Ave. Joyce Flohr/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/2007 Pleasant Hill Cem Monrovia, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service any 1621 Opossumtown Pike, Frederick, MD 21702 23a. Par 1. En 121 e disease, or conscicutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** demic /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit crastroin attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 X FR/Outpatient 3 □ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No filled in by the funeral 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Han Kohver
31. Date filed (Month, Day, Year) State JUN 1 9 2007 Registrar

			1 _ State	partment of Health and leartificate of Death			21218
			1. Decedent's Name (First, Middle, Last)	er tillicate or Death	2. Date of Death	- No:	3. Time of Death
П	Physicia	an			Month	Day Year	
	/Medic		STEPHEN GRAVES 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	JUNE 09	4c. County of Death	2:20 A ™
<i>}</i>	Examin	er	DOCTORS COMMUNITY HOSPITAL	LANHAM		PRINCE GE	ORGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Y		place (State or Foreign
ŀ	Director		241-66-8615 1 MM 2 □ F 62 Yrs.	World Days Hours Will.			H CAROLINA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryla f sho	0	Maryland Prince Georges Suitlan	d			1 X Yes 2 □ No
	the rotif	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?
	h with		2313 Brooks Dr. #303	20746		U. S. A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer □ Yes 2□ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: B1	
ĕ	2 hou	ted		cedent's Usual Occupation	rking 16	6b. Kind of Business/li	ndustry
215	thin 7 e. an "n Medj	eg.	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)			
7	ed wil	Completed		hine Operator		Private	
n D	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) RUFUS M. GRAVES		me (First, Middle, Ma JOHNSON	aiden Surname)	
2	2 should be filed and Mental Hygi is marked other aumatic event, the	ပ္		ailing Address (Street and Number or Ri		City or Town State 7	in Code)
<u>a</u>	d 2 sl th an traur		112	Brooks Dr. #303			· · · · · · · · · · · · · · · · · · ·
ē,	f Hea f Hea tem 2		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of rematory or other place)		Oc. Location - City or T	
9	Pages nent of I ant: If ite ury or of		121 Burial 2 Defermation 3 Defermoval from State	11e Church Cem. 6/	/16/2007 Y	ancevville	. NC
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike	•		
	4		23a. Part1. Inter the disease, or complications that caused the death. Do not shoot, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition as METASTATIC LUNG resulting in death)				Onset and Death YEARS
	Examiner		Due to (or as a consequence of):				
L		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted Id ransit	Examiner	that initiated events C.				
Ö,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
8760	ate hy:	dical	d				
Ó	ertific ling p	Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy				
P.O. Box	The law requires that the death certificate has been signed by the attending plange 2 should be detached for use as to	Physician/Med	in the past 12 months?	3 ⊟Ectopic pregnancy 5 ⊡ Other (specify)		23d. Date of deli	very Day Year
	w requires that s been signed t should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	
ğ	equire en sig	edt	PNEUMONIA, HYPERTENSION		1 ☐ Yes	: 2 □ No 3 🛣 Pro	bably 4 Unknown
ပ္ပ	has be ge 2 sho	Completed			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
œ	The ate h	E O			performe	ed? death?	2 No
<u>ita</u>	i ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?		ath (Check only one))	
7	Physi this c al dire	²	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 □Other (Spec	ify)
Division or Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, I	Certification:	27. Manner of Death 1 ▼ Natural 5 □ Pending (Month, Day Year) 28b. Tim Injury		28d. Describe how	vinjury occurred	
S	or Attendatter death Director: in by the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,		28f. Location (Stre	eet and Number or Ru	ral Route Number,
<u>S</u>	after after I Dire	erti	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o				
	To the within 2 To the complet	Me	29b. Signature and Hite of certifier	29c. License number		d. Date signed (Month	
			1 NSV2 MD	D48213	J	UNE 11, 20	U/
12	(10)		30. Name and address of person who completed cause of death (Item 23a) (Tyn NEELAM ASHAI, MD 4410 74th AVE.	, LANDOVER HILLS,	MD. 2078	4	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 5 2007 JUN 2 5 2007 JUN 2 5 2007	7			
	9.0.1		JOH T O TOO. TOTAL YOU !!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 14 2007 JUNE 1:50 PM GARRETT BERYL S. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Days 1 □ M 2 🖫 F Months 1922 NORTH CAROLINA 84 243-38-8894 OCT. 26 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 10450 LOTTSFORD ROAD 20721 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 🔀 No black 1 ☐ Yes 2 ☐ No Specify Specify 3☐Widowed 4☐Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 12th GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE SMITH ETHEL COOPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CRYSTAL TYLER/GRANDDAUGHTER 2614 SAWGRASS RIDGE PLACE CHARLOTTE, N.C. 28269 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Lown State NORTH CAROLINA 1 Burial 2 □ Cremation 3 ☐Removal from State ELLIS LEE CEMETERY 6/20/2007 4 ☐ Donation 5 ☐ Other (Specify) PLYMOUTH. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JENKINS FUNERAL HOME J. B. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure? List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Sepsis Due to (or as consequence of): Bleec G-1 Sequentially list conditions, if any, leading to imm. Tate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

ပ

Funeral

Director

e filed within 72 hours after death with the Maryland al Hyglene.

other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Varret

Examiner Physician/Medical

and burial-tra attending physician for use as the buria this filled in by the funeral To the Hospital or Attending P within 24 hours after death.
To the Funeral Director; After

ģ

Completed

Be

မှ

Medical Certification:

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acidosis

24a. Was an autopsy

26. Place of Death (Check only one)

1 🗌 Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number DO058213 611417

29d. Date signed (Month, Day, Year)

Jamah afashun

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARHAD JAMALI

iem 23a) (Type, Print); ; 7305 Hanover PKWY Greenbelt MD 20770

State Registrar

31. Date filed (Month, Day, Year) JUN 1 8 2007



MD

completely

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20^{Day} June **Physician** 2007 12:00 AM Beverly Ann Gilbert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Forest Hill Health & Rehab Ctr. Forest Hill Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | 9 | Magth | Day 4 Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland 1 □ M 2 X F Director 216-38-7296 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or Items 23a or 28a-f show the Madical Examiner roust be notified at 1 ☐ Yes 2 ☐No Director Harford Belcamp MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21017 1304 Cranesbill Ct. Unit 301 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Maricel Ext. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail 12 Sales person 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Priet Elmer Bena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna L. Pezzella (Daughter) 1212 Hickory Brook Ct. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/21/07 West Chester, PA * 4 ☐ Donation 5 ☐ Other (Specify) A. Ferris & Co. 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic lung cancer Co month 9 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner ng physician and as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes or Attending Physician: ours after death.

erat Director; After this certificalitied in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOWY 9050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 15 S. Parke Street # 400 Aberdeen MD 2100 Vrashant Shukla 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State	of Man	yland	-	artmen <i>tificat</i>			and M	ental Hy	giene Reg. No.	007	2	1221
Physi /Med		n	1. Decedent's Name (First, Middle Mary (a)	therin	e	6.	200	ì				2. Date of De. Month	Day	100 Year		Time of Death
Exam			la. Facility Name of not institution	/	umber)	Hon	0			Location o	/	nd		County of De	ath	
Funera	al		Longview 5. Social Security Number	6. Sex			st birthday)	Il Under Months	1 Year	If Under:		8. Date of Birt (Month, Da		rroll 9. Bi	rthplace	(State or Foreign
Directo			215-48-6851 Usual Residence of Decedent	1 □ M 2 □ X F		78	Yrs.	Mortins	Days	Hours	IVIII.	6/7/19	29.	Ma	ryIa	nd
nyland show	١,		10a. State 10b. County		10	0c. City,	Town or Lo	cation								nside City Limits
the Ma	Cinatal Disease	1 60	Maryland Carro	11	I N	/lancl	nester	10f. Zip	Code				10a Citiz	en of What C		Yes 2 XNo
h with	Š	2	3332 Main Stree	et					102					ed Sta	,	
er deat		uner	11. Marital Status	12. Was De Armed F	orces?	er in U.S.	13. \	Vas Deced Yes, spec	ent of His	spanic Ori	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.)	- 1	4. Race - Arr Black, Wh		dian,
al', or l	12	ል	1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	lf Yes, C Year or	2 ZNO ive Dates:		1	I□Yes :	2XNo	Specify:				Specify: W	hite	
Deficiency is the property of the composition of th	Potel	Completed	15. Decedent (Specify only highes	t's Education st grade completed	1)		16a. Deced	lent's Usua kind of wo	rk done d	urina mosi	t of workii	ng	16b. Kin	d of Busines	s/Industry	1
d withig		d o	Elementary/Secondary (0-12)	College	(1-4or 5+)		None) (NO 1 LS	60 10(1100)							
be file d oth	á	D	17. Father's Name (First, Middle,									(First, Middle,		Sumame)		-
should nd Mer mark	F	2 -	William L. Gree 19a. Informant's Name/Relations				19b. Mailin	g Address	(Street a			earl Ra <i>I R</i> oute <i>Numbe</i>		Town, State,	Zip Code	e)
and 2 ealth a m 27 ie			Shirlee G. Else	erod - Ni						ad Re		rstown,				
Pages 1 nent of H int: if ite		1	20a. Method of Disposition 1 Burial 2 Cremation			cen	ce of Disponetery, cren	natory or o	ther place		/14/:	ate		ation - City o		
permit. P Departme Important any injury	ġ	-	4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service				22	. Name an				ine Fun		stead, Home		
0 8855	Suc		Om II			M014	1.10				pste	ad, Mar	yland		4	
Physicia			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	e death,		~		1	cardiac o	r respiratory ai	rrest,		Inte	roximate rval Between et and Death
/Medica	al		disease or condition resulting in death)	a. Due to	(drasa c	onsetine	nce of):	Cm	w						19	~
Examine		5	Sequentially list conditions, any, leading to immediate cause. Enter Underlying	b. — Quali	(or as a o	unseque	nce of):									
cuted nd iransit	1	E	that initiated events	G												
ate be executed hysicien and the burial-transit		Carex	resulting in death) Last	- Due to	o (or as a c	eupeano	ince of);									
tificate og phys				d												
ath cer	Developm/Mad	any	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal d	leath 3	Ectopic pr					2:	3d. Date of d Month	elivery Day	Year
the de ached) ave	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at tim nown	ie or dea	iin 5∟	Other (sp	өспу)							
or Attending Physician: The law requires that the death certificate be executed attending Physician: The law requires that the death certificate be executed blirector: After this certificate hes been signed by the ettending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	1	<u>ה</u>	Part II. Other significant condition	ns contributing to	death but n	not result	ing in the ur	nderlying c	ause give	n in Part I.						use of death?
w requi	Completed											24a. Was	Yes 2 2			indings available
The la The la ete hes page 2	1	E										autor	med?	prior to death? 1 \(\subseteq Yes	complet	ion of cause of
vician: certific rector,	å	0	25. Was case referred to medical examiner?	Hospital:			- THE STATE OF THE		Othe	_		(Check only o	ne)			
g Physical chis	F		1 ☐ Yes 2 ₽ No 27. Manner of Death	28a. Date	Inpatient of Injury onth, Day Y	2	R/Outpatien 8b. Time of		8c. Injury Work	4 🖂 NU		ne 5 ☐ Resid 28d. Describe I			ecify)	
tendin death. tor: Aff	1	Cario	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	gation			Injury	М	1 🗆 Y	res 2□						
atter of Air Directed in Directed	Cortification.		4 Homicide determ	ined 288. Place	ding, etc. (- At hom Specify)	ie, farm, str	eet, factor,	r, office			281. Location (3 City or Tox		Number or i	rura: Hou	ite Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		!	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of n basis of ex	aminatio	edge, death on and/or inv	occurred restigation	at the tim , in my op	e, date an inion, dea	id place, a	and due to the ed at the time,	cause(s) a date and	and manner a place, and di	is stated.	cause(s)
To th To th comp	N		29b. Signatore and title of certifier	h				290	License	number	1.60		29d. Date	signed (Moi	nth, Day,	Year)
Hou			30. Name and address of person	July sometical as	Ut	th (Itam	MN (T) (7)	Print)	(((M,	4 4.	5	4	14/	206	7
2			John W. Mik	elleton v	100	688	Past	e K	21.	11/	estin	inste	L V	40	2	1157
S Regis	State stra		31. Date filed (Month, Day, Year) JUN 15	L.	Registrar's	Signatu	re do	redle s	,	,						4

1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year June 12 2007 18:10 PM				•	For State	State of Ma	arylan		artment of F <i>rtificate of</i>	Health and M Death	lental Hy	Lo	1007	2/222
Description Color			3:			st)			incate of	Death	2. Date of De	ath		3. Time of Death
South Harm of Memorial Plans South Harm of Memorial Plans		ш			Lottie Mae Gu	v								18 · 10 pM
Harford Memorial Hospital Hospital Have de Crace Harford Burgasad olite or fundament 10 10 10 10 10 10 10 1				_		,			4b. City, Town, o	or Location of Death	o arre			10.10 IM
Discort Security Numbers					Harford Memorial	Hospital			Havre d	e Grace		Ha	rford	
Tell Agency and Number Tell Agency Tel			Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birthp Coun	ace (State or Foreign try)
The County The		4	Director		216-56-3881	LIM ZAT	83	Yrs.			Dec. 1	2, 19	23 Kent	ucky
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add			land II				10c. City	, Town or Lo	cation				1	Od. Inside City Limits
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add			Mary	ţ	Manual ond Coada		Por	t Dono	ci+					1 ☐ Yes 2 XNo
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add			r 28a	irec			FUL	с реро				10g. Citize	n of What Cour	try?
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add			th with	O E	6 Benjamin Drive				21903			Unit	ed Stat	es
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add			ams (ner		12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (Spetan, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14		
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add		36	or it	y Fu		1 ☐ Yes 2 💢 t	No							
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add		Ö	hours iural',	Q D	A							16h King		
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add	0	75	in 72	jete	(Specify only highest gra	ide completed)		(Give	kind of work done DO NOT use retire	during most of work d)	ing	100. Kare	1 Of Dusinessyllin	ustry
Josh Small 19a Informants NameRelationship (Type, Print) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (Street and Number Colly or Town, State, 25 Code) 19b Mailing Address (State, 25 Code) 19b Mailing Add	5	212	with iene	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)					Own	Home	
Josh Small Josh S	_		othe	e C	17. Father's Name (First, Middle, Last,	1				18. Mother's Name	e (First, Middle			
20. Method of Disposition 10 Disposition 10 Disposition 11 Disposition 11 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 12 Disposition 11 Disposition 12 Disposi		<u>Iar</u>	Q 20 0 0	0	Josh Small					Ada Sma	11			
20. Method of Disposition 10 Disposition 10 Disposition 11 Disposition 11 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 11 Disposition 12 Disposition 12 Disposition 11 Disposition 12 Disposi		lan	2 sho and 1	. 4		Type, Print)								
Compared to the past of the			무를 2 할				100h D	1					_	
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Page 1	07	ore	ges 1 t of H if its or otl			Removal from State				I I				
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Page 1	1	Ë	t. Partmen	1 3			New	-						Maryland
Physician / Medical Examiner Physician / Medical Examiner	_	Ba	Departiment Departiment Departiment Departiment Departiment Department Depart		21. Signature of Juneral Service Licel	1588								yland 21901
Physician //Mcdical Examiner Throughout the first of the	3				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death	n. Do not ent	er the mode of dyl	ing, such as cardiac	or respiratory a	arrest,		Interval Between
Due to (or as a consequence of): Sequencially list conditions as consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions as consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of): Sequencially list conditions and consequence of):			Physician		Immediate Cause (Final		Om	00	lin h	29. 1 Pa	3.014.0			INKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause pleases or injury or cause of the		4			resulting in death)	Due to (or as	a consequ	uence of):	A .			· · · · · · · · · · · · · · · · · · ·		701 11 110 1
The proposed of the property o			Examiner	_	Sequentially list conditions,	b	U	rial	Jelsil	Vation				
Part Color	9	S	ed sit	nine	rif any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	Jence or):	,) st.	d.0-			
Part Color			xecul and al-trar	xan	that initiated events	C. Due to (or as	a consequ	uence of):	and C	nun	Clubb	in X		
The past 12 months of the past 12 months of	2	200	sicier sicier s buri		· ·	d								
The past 12 months of the past 12 months of	-	89	ificate g phy as the			0.								
1)20215 6-12-2007	70	ŏ	h cert endin	M/UR	23b. Was decedent pregnant				Tectonic pregnanc	עיי		23		
1)20215 6-12-2007	至	Э.	a deat he att ed for	sicia	1 ☐ Yes 2 ☑ No	4□Pregnant at				·,			Month	Day Year
1)20215 6-12-2007	J	P.C	at the	Phy				late of the state of		Spin 2002	22a Did	10h		an anum of death?
1)20215 6-12-2007	1	8	res th	þ	Part II. Other significant conditions of	Ontributing to death b	ut not resi	uiting in the u	ngenying cause gr	ven in Parti.				
1)20215 6-12-2007	2	20	requ	etec		y eff	69 CV	}				-		^
1)20215 6-12-2007	N	Zec	e law has l	E E							auto	psy	prior to co	mpletion of cause of
1)20215 6-12-2007)	<u>a</u>	n: Tr ficete or, pag	O	25 Was sans referred to medical					00 Diversión	1	-	1 🗆 Yes	55 00
1)20215 6-12-2007		<u>=</u>	s certi	00	examiner?	Hospital:	ant 2 🗆	EB/Outpaties	ot 3D DOA Ot	her			□Other (Specif	v)
1)20215 6-12-2007		0	g Phy er thi		27. Manner of Death			28b. Time o						
1)20215 6-12-2007		Ö	ath. vr: Aft	atio	2 Accident investigatio	n	y 1 021/	inquiry						
1)20215 6-12-2007		ivis	or Atte fter de Siracto in by th	rtific	determined	289. Place of In	ury - At ho c. <i>(Specif</i>)	ome, farm, st	reet, factory, office				Number or Rura	I Route Number,
1)20215 6-12-2007			ours a		29a Certifier 152-Sertifying Pl	vsician: To the hest	of my kno	wiedne deat	h occurred at the tr	me date and place	and due to the	a cause(s) a	nd manner as s	lated
1)20215 6-12-2007			ha Hos in 24 h he Fun pletely	0	(Check only 2 Medical Example 1	miner: On the basis o	f examina					, date and p	place, and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. NAR, MD State Registrar 31. Date filed (Month, Par, Year) 5 2007 32. Registrar's Signature, April 1000 33. Registrar's Signature, April 1000 34. Registrar's Signature, April 1000 35. Registrar's Signature, April 1000 36. Registrar's Signature, April 1000 37. Registrar's Signature, April 1000 38. Registrar's Signature, April 1000 39. Registrar's Signature, April 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) April 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) April 1000 A			with To t	Σ	29b. Signature and title of certifier	MAR							-	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Mo				1		TYLL				110001	3	0-	10-0	, , ,
State Registrar 31. Date filed (Month, Pay Year) 5 2007 32. Registrar's Signature			r		Α	completed cause of c	leath (Item	23a) (Type,	Miu-	ave- le	round	o grec	o , MO	21078
					31. Date filed (Month, Pay Year) 5	2007 32. Redistr	rar's Signa	ture	Joseph					

Certificate of Death

29d. Date signed (Month, Day, Year)

	9	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		Voor	3. Time of Death	
Physici /Medi		EDMON SINDALI	HURTT GOULI)			JUNE	25 2	2007	7:30a	
Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	Location of Death		4c. County	of Death		
		13065 Kentmore	e Park Rd.		Kenned			Ken			
Funeral		5. Social Security Number 6. S	M		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		ace (State or Foreig try)	
Director		213-78-6186	58	Yrs.			Mar 18	1949	Mar	yland	
and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				11	Od. Inside City Limit	
sho ed at	ō	MD Kent		-	ville					1 □ Yes 2 □ K N	
the A	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of	What Coun	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Di	13111 Shallcr	oss Wharf Ro	. F	21645	;	"	U.S.A		.,,	
ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		ce - America		
after or Ite	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		il res, specily cub. 1 □ Yes 2 🛣 No	Specify:	o nican, etc.)		ick, White, 6	hite	
ral", c	i by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 1 1 es 2 E F 1 0	орвону.		Specif	y: •••		
72 h 'natu dicai	Be Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king	16b. Kind of B		lustry	
vithin ne. han '	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		abled	3)		Menta	-	a	
led w lygie her ti	ပိ	17. Father's Name (First, Middle, Last		DISC	Died	18 Mother's Nam	ne (First, Middle, N			u	
tal H	Be	William Dunba									
hould d Me nark	2	19a. Informant's Name/Relationship		19h Mailir	ng Address (Street		Voodland				
d2s than 17 Is		Margaret A. C		ster)		Kentmor		-		- 210	
1 an Heal em 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	ĭ		20c. Location			
ages int of t: # it	20a. Method of Disposition 1										
artme artme ortan Injury		21. Signature of Euneral Service Lice			_				-	•	
permi Depar Impor any Ir once.			M00!	510 G	Name and Address Fig. 18 West	neral H Cross S	Home of St. Gale	Steph ena. M	ien L 1D. 2	Schae	
		23a. Rant Enter the disease, or comshock, or heart failure. List only	plications that caused the deal	h. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Alzho	imei	c's D	omen	tic			Onset and Death	
/Medical		resulting in death)	Due to (or as a consec	uence of):	0	drom	, , ,			2442	
Examiner		Sequentially list conditions	b. Down	1'5	Syn	drom	1				
D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):							
ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c								
e exi		resulting in death, East	Due to (or as a consec	uence or):							
sath certificate be executed attending physician and for use as the burial-transit	cian/Medical	•	d						_		
ding page as	/Me	IF FEMALE:	23c. if yes, outcome pf pregn	ancv				004 0	-46 -1-1		
	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	aldeath 3	□Ectopic pregnanc: □ Other (specify) _	у			ate of delive Ionth	ry Day Year	
the de	Physic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	Jean 3L							
that the ed by detail	h h	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?	
uires that the de signed by the a Id be detached to	d by						1 □ Ye	s 2 No	3 🗆 Prob	ably 4 □Unkno	
w requir been si should I	Completed						24a. Was a	n 24h	Were auto	psy findings availa	
he lar has ige 2	d L						autops perforr	y ned?	prior to cor death?	npletion of cause of	
ificate or, pa		25. Was case referred to medical				26 Place of Dog	1 Yes 2 th (Check only on	2 12-170	1 ☐ Yes	2 No	
s cert	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	LEB/Outpatie	nt 3□ DOA Oth		ome 5 Reside		her (Specifi	, siste	
Attending Physician: The law requires that the de releath. cleath. ector: After this certificate has been signed by the actor; After this certificate has been signed by the actor by the funeral director, page 2 should be detached.	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe ho			_ nome	
nding th. r: Afte e fun	# 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										
Atternation of the part of the	ifice	3 ☐ Suicide 6 ☐ Could not be determined			reet, factory, office		28f. Location (St City or Town		ber or Rura	Route Number,	
s afte	ert	4 El riomiolde	building, etc. (<i>apeci</i>	77			July of Town	, Jiale)			
Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been signe itely filled in by the funeral director, page 2 should be	ical Certification:	29a. Certifier 1 Certifying P	nysician: To the best of my knowniner: On the basis of examina	owledge, deat	th occurred at the ti	me, date and place	, and due to the c	ause(s) and m	nanner as s	tated.	

State Registrar

Paul Donaher, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

29c. License number

119 C. North Main St. Galena, MD.

D58824

5

John Haden (136 (634 6-17-300) Baltimore, Maryland 21215-0036

		= State Registrar					artment of F			Reg. N	lo.	1 2 2 2 4	_
hysicia	n	1. Decedent's Name JOHN		OLDEN, JR					2. Date of Month)ay Ye a /07	3. Time of Death 6: 51 P M	
Medica amine		la. Facility Name (If r					4b. City, Town, o	r Location			c. County of De	ath	
		MANOKIN					PRINCE				SOMERSE.		_
al or		5. Social Security Nur 142-12-9	678	TM 2005	e (In yrs. Ias 34	t birthday) Yrs.	If Under 1 Year Months Days	Hours	8. Date of (Month O1/2)	Day, Yea 1/23	9. E	Sirthplace (State or Foreign Country) IRGINIA	_
9	-	Usual Residence of D 10a. State	10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits	
	cto	MD	SOMERS	ET	PRI	NCESS	S ANNE					1 Yes 2 No	
	Funeral Director	10e. Street and Numb		VE APT 304	<i>.</i>		10f. Zip Code 21853				Citizen of What USA	Country?	
	eral	12370 SU	HERSEL A	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H	lispanic Or	gin? (Specify Yes o	r No-	14. Race - Ar	merican Indian,	_
	þ	1 Never Married		Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No		If Yes, specify Cuba 1 ☐ Yes 2 💢 No	an, Mexicai Specify:	ī, Puerto Rican, etc.)	Black, W.	hite, etc. BLACK	
1	Completed		15. Decedent's Ed			(Give	dent's Usual Occup	during mos	t of working	16b.	Kind of Busines	ss/Industry	
	du	Elementary/Second	dary (0-12)	College (1-4or 5	5+)	LABO	DO NOT use retired DRED	3)			POULTRY		
		17. Father's Name (F	First, Middle, Last)				JILLIL.	18. Moth	er's Name (First, Mic				
	To Be	JOHN W.	HOLDEN,	SR.				DH	LIA HOLDE	N			
		19a. Informant's Nan GEORGIAN							er or Rural Route Nu VE APT 30				5.5
		20a. Method of Dispo		Removal from State	20b. Plac	e of Disponentary, crea	osition (Name of matory or other place	ce)	Date		Location - City		
		° 4 ☐ Donation_5	□ Other (Specify		GROT		OMMUNITY		06/21/07	1	MESSONG(O, VA	
any injury or once.		21 gnature of Fun	UNV 10	OCOM	J		2. Name and Addre	HUMBI	RS FUNERA	L CO.	. ACCO	MAC, VA 23301	L
		23a. Part1. Enter the shock, or heart	disease of comp failure. List only	plications that caused one cause on each i	the death. he.	Do not en	ter the mode of dyir	ng, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
ian cal		Immediate Cause (F disease or condition resulting in death)	inal	a	AS	CVD			· · · · · · · · · · · · · · · · · · ·				
er				Due to (or as	a conseque	nce of):							
	Jer	Sequentially list condificant, leading to immocause. Enter Underline Cause (Disease or in	ditions, nediate	b. Due to (or as	a conseque	nce of):							
	Examiner	that initiated events	_	c									_
		resulting in death) La	ist	Due to (or as	a conseque	nce or):							
	dice		•	d									_
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3[□Ectopic pregnanc □ Other (specify) _	у		_	23d. Date of Month	delivery Day Year	
	ed by Ph	Part II. Other signific	cant conditions of	ontributing to death b	out not result	ing in the u	underlying cause gru	en in Part	-	Did tobacc		to the cause of death? Probably 4 Dunknown	
	omplet									Was an autopsy performed es 2 X	prior death	autopsy findings available to completion of cause of ? 'es 2 \square No	
ctor,	Be	25. Was case referre	ed to medical	11 2.1					e of Death (Check o	nly one)			
	2	1 ☐ Yes 2 📉 N	lo	Hospital:		R/Outpatie		4 AN	ursing Home 5 1		6 □Other (S	pecify)	_
5	ilon:	27. Manner of Death 1 Natural	5 Pending investigation	28a. Date of Inju (Month, Da	ly Yeer)	8b. Time o Injury	Wo	ryat rk? ∣Yes 2.⊑		IDA HOW II	ijury occurred		
III by are	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		jury - At hom tc. (Specify)	e, farm, st	reet, factory, office		28f. Locati	on <i>(Stre</i> et r Town, St	and Number or ate)	Rural Route Number,	-
completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner: On the basis of and manner st	of examination	edge, deal n and/or ir	th occurred at the ti nvestigation, in my o	me, date a opinion, de	nd place, and due to ath occurred at the ti	the cause me, date a	e(s) and manner and place, and c	as stated. due to the cause(s)	
compi	Me	29b. Signature and t	itle of certifier				29c. Licens			29d. i	Date signed (M	onth, Day, Year)	
		N	oliv				04	7091	1		6/18/07	>	
	- 114						,				V Ry		

DHMH 17 Rev 1/2001

	4	For State Registrar	State of Ma	-		nt of Healt te of Dea			iene og. No.	0.7	21225
Physicia	_	1. Decedent's Name (First, Middle, Last)	arl H	elner	ma	n		2. Date of Deat Month JUNE 1	Day	Year	3. Time of Death 8:00 A M
/Medica Examine		4a. Facility Name (If not institution, give		9	4b. City	, Town, or Locat			4c. County	of Death	
Funeral Director		5. Social Security Number 6. Sec		(In yrs. last birthd:	Months	r 1 Year If Un	nder 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthpi	ace (State or Foreign
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10	Od. Inside City Limits
the Mar 28a-fa	ector	MRYIAND ANNE ARI	INDEL			NAPOLIS p Code			Og. Citizen of V	What Coup	1 ☐ Yes 2 XNo
th with 23a or	a Di	1175 LATROBE DRIVE	:		, 01. 2		1409		UNITE		
5-0036 72 hours after dea natural; or Items	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		3. Was Dece If Yes, spi 1 \(\text{Yes}	ecify Cuban, Me	c Origin? (Spe xican, Puerto ocify:	ecify Yes or No- Rican, etc.)		e - America k, White, e	etc.
within then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)		(G	ive kind of w e. DO NOT	ual Occupation ork done during use retired)	most of worki	ing	16b. Kind of Bu DISABLE ADULTS		LLDREN AND
€ d a b 5	To Be C	17. Father's Name (First, Middle, Last) SAMUEL GUY THOMPSO	N .					First, Middle, I			
re, Maryla s 1 and 2 should f Heelth and Mer Item 27 1s marke other trsumatic		19a. Informant's Name/Relationship (Ty DANIEL THOMPSON HE			-	•		al Route Number			
	4	20a. Method of Disposition		20b. Place of Di	sposition (Na	ime of			20c. Location -		
Baltimore, permit. Pages 1 ar Department of Hee Important: If Item any Injury or othe	Ī	1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipens:	e	CHESAPEZ CENTER 400672			JUNE 2007 acility FFL FUNERA	13, S LOWS, HE AL CARE, RYLAND	TEVENS	HIE.	MARYLAND YEWNAM BESTCATE
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or		he death. Do not	enter the mo	ANNAPOL de of dying, such	h as cardiac d	or respiratory arre	21401 °		Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. De	men	+10						Onset and Death
Examiner		Sequentially list conditions,)	consequence of):							
uted ansit	mlner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	Due to (or as a	consequence of):							
icate be executed physicien and sthe burial-transit	ai Examin	resulting in death) Last	Due to (or as a	consequence of):							
D = - 2	Medicai		l								
at the death certifi by the ettending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death	3 □Ectopic p 5 □ Other (s				23d. Dat Mo	e of delive nth	ry Day Year
S transfer t	<u>م</u>	Part II. Other significant conditions cor	itributing to death but	not resulting in the	e underlying	cause given in P	art I.	23e. Did tot	.1		e cause of death? ably 4 Dunknown
al Records, The law requires t cate has been signe page 2 should be	Completed							24a. Was a autops perform 1 ☐ Yes 2	neyd?	Vere autor prior to con death?	osy findings available inpletion of cause of
ysiclan: T ysiclan: T is certificat director, p	To Be	25. Was case referred to medical examiner? 1 Tyes 25 No	lospital:	t 2 ☐ ER/Outpa	tient 3□ D	Other		n <i>(Check only on</i> me 5 ☐ Reside	/	ASS er (Specify	istea
		27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day	28b. Time		28c. Injury at Work? 1 ☐ Yes		28d. Describe ho			,
DIVIS Ital or Attures after de al Directe led in by It	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y · At home, farm, (Specify)	street, facto	ry, office		28f. Location (St City or Town		er or Aura	Route Number,
e Hospi 124 hou e Funer letely fill	Medicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of per: On the basis of e	xamination and/or	eath occurred r investigatio	d at the time, dat n, in my opinion,	te and place, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place,	nner as stand due to	ated. the cause(s)
To th withir To th comp	Ň	29b. Signature and title certifier	ho.		25	c. License numb	ber 7 1 1 1 5	2	9d. Date signed	(Month, I	Day, Year)
	-	30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Typ	pe, Print)	000	CPIC		(4)	11/	01
W	0	Arvind Des	32. Negistrar	Roes	SIEV	Kd E	ilen	Burn	ic M	<u>d</u> 2	21060
Stat Registra	_	JUN 1 5 200	7 Langua	J. H.	dog with	A.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 12:15 A^M June 15, Nice Helms 2007 Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 23, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 80 1926 Pennsylvania 168-20-8157 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rthan "natural", or Iteme 23a or 28a-f ehow Us Medical Examiner must be notified at 1 Yes 2 No Directo Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 **IISA** 18448 Cape Jasmine Way Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Apparel Store 5+ Retail Sales es 1 and 2 should be filed of Health and Mental Hygis of Health and Mental Hygis If Item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard David Nice Esther Hoag 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18448 Cape Jasmine Way Gaithersburg, MD 20879 Richard C. Helms/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: If les
eny Injury or oth 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 06/19/07 Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Carcinoid **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the al d be deteched fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably paga 2 should peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed certificate 1 Yes 2 No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) , 2 No မှ 1 Tes 3 DOA To the Hospital or Attending Pr within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Dey, Year) 15 who completed cause of death (I)em 23a) (Type, Print) 30. Name and address of person Ave. Gaithersburg Teven alinst-CU 5501 32. A gistrar's Signature 31. Date filed (Month, Day, Year) State **JUN 19** 2007 Registrar marke

			Please	e Type or Prir								gible.	
		For State Registrar		State of Ma	arylan	•	artment of F ertificate of				- 0	no a	2122
		Registrar 1. Decedent's Name	e (First, Middle, I	Last)	-		Timeate of	Dealli	2.	Date of Dea		No. of I	3. Time of Death
Physicia /Medica		Janin	ie I	F. Harr	ison					Month 5	Day 16	200 7	0811 M
Examine	1.0		//	ive street and number)	0		4b. City, Town, o	-			1.1	nty of Death	
Funeral		5. Social Security N		SEX T. AG		NTER last birthday	If Under 1 Year	BUR If Under	r 24 Hrs. 8.	Date of Birth	1	9. Birth	place (State or Foreign
Director		179-52-70		¹ □M 2 X F 5	8	Yrs.	Months Days	Hours	Min.	(Month, Day 3/13/1	948		nown
land bw t		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
a-f sho	cto	Maryland	Wicom:	ico	Sa	alisbu	ıry						1 Xes 2 No
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Öire	10e. Street and Nur					10f. Zip Code				10g. Citizen	of What Cou	ntry?
eath v	Funeral I	11. Marital Status	ris Driv	12. Was Decedent	Ever in U.	S. 13.	21804 Was Decedent of H If Yes, specify Cub		rigin? (Specify	y Yes or No-	USA 14. F	Race - Ameri	can Indian,
ours after de iral", or Item Examiner i	F		ied 2□ Married	Armed Forces? 1 ☐ Yes 2 If Yes, Give	No		If Yes, specify Cub 1 ☐ Yes 2 ☐ No			an, etc.)		Black, White,	
hours ural",	d by	3 🗌 Widowed		Year or Dates:		16a Doo	edent's Usual Occup				منطعم	f Business/Ir	nite
iin 72 n "nat Nedica	Completed	(Spec	, , ,	grade completed) College (1-4or s	54)	(Giv	e kind of work done DO NOT use retire	during mo d)	st of working		Tob. Killa o	i Dusilless/li	idustry
ed with ygiene rer tha r, the I	Som	unknow	m i	Ō		ment	ally hand				none		
I be file ntal H ed oth even	Be	17. Father's Name unknown	(First, Middle, La	st)				unkr	ner's Name <i>(F</i>	irst, Middle,	Maiden Suri	name)	
2 should and Men is marke raumatic	ဍ	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mai	ling Address (Street			Route Numbe	er, City or To	wn, State, Zi	p Code)
and 2 ealth a n 27 is ner trai		Scott Ba	lker/ope	erations mg									, MD 21801
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natunany Injury or other traumatic event, the Medical once."			Cremation 3	☐Removal from State			oosition (Name of ematory or other pla		Date			on - City or T	
nit. Pa artmer ortant: Injury E.		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Spe		Sal		y Cremato 22. Name and Addre		5/23/0			bury,	
permit. Depart Import any Inj		1	Well	elle			Holloway 501 Snow	Fune: Hill	ral Hor Rd., S	ne Pro Salisb	iessic ury, N	nal A 1D 218	ssociation 04
		23a. Parl 1. Enter t	the disease, or co art failure. List or	omplications that couse only one cause on each li	d the deatl	h. Do not ei	nter the mode of dyi	ng, such a	s cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)		a		Gr	ound le	uel	Feill				2
Examiner				Due to (or as	a conseq	uence of):	b dural	her	nata	va			
p #	ner	Sequentially list contains to the cause. Enter Under	nmediate erlying	b. Due to (or as	a conseq			·					
e executed ian and urial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	S 🔳	c Due to (or as	a conseq	uence of):							
e be e /sician e buria	_			d	·								
eath certificate be attending physici for use as the bu	Physician/Medica	IF FEMALE:	-			-							
ath ce attendi for use	jan/	23b. Was deceden	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗆 Feta	death 3	□Ectopic pregnanc	у			23d.	Date of delive	very Day Year
at the de by the tached	hysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐Unknown	t time or d	oaiii 3							
Hospital or Attending Physician: The law requires that the death certificate be 4h hours after death. Funeral Director: After this certificate has been signed by the attending physicia itely filled in by the funeral director, page 2 should be detached for use as the bur	by P	Part II. Other signi	ficant condition	s contributing to death b	out not res	ulting in the	underlying cause giv	ven in Part	l.			_	the cause of death?
w requires to been signer should be	eted												bably 4 Unknown
he law e has l	Completed										rmed?	prior to co death?	opsy findings available ompletion of cause of
Physician: The law r this certificate has t ral director, page 2 s	BeC	25. Was case reference examiner?	rred to medical					26. Plac	ce of Death_(C		2 L No	1 ☐ Yes	2 □ No
Physic this ce	٩	1 √ Yes 2 □		Hospital: 1 Inpati		ER/Outpatie	BILL 3 DOA		Nursing Home				ify)
ding h. h. funer	tjon:	27. Manner of Dear 1 Natural 2 Accident	tn 5 ☐ Pending investigat	28a. Date of Inju (Month, Date)	y Year)	28b. Time Injury	Wo	ıryaτ vrk?]Yes 2[]	/		now injury oc al level	_	
Atten er deat ector: by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	the 28e Place of in	iury - At ho	ome, farm, s	treet, factory, office		28f	Location (S	Street and No	umber or Ru	ral Route Number,
ital or ars afte ral Dir lled in	Cert	9		Huma	nin	nay C		ndthi		Holl	y (ente		-8 marro Dr.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)		Physician: To the best caminer: On the basis of and manner si	of examina								
To the comp	Me	29b. Signature apo	title of certifier				29c. Licen				29d. Date si		, Day, Year)
			MM					044]		5/1	6/07	
6		0.	ress of person w	ho completed cause of $\mathcal{D}_1 \circ \mathcal{D}_1$	F	180	E (A CON!	17.	Salist	my n	W 21	१०५	
Sta		31. Date filed (Mor	nth, Day, Year)	2. Regist	rar's Signa	ature	2			,			
Registra	ar	JU	IL 0 2 20	W/ Alaras		Spa	الميانية						

Registrar

State

Apgar

Boy,

32 Registrar's Signature

07-04410 Eric Girard Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

0	00,100			ate of Death	Reg. N	
Ph	ysicia		edistrar . Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 0422 hrs
	xamir	er	Eric Girard Jones		June 9, 2007	4c. County of Death
		4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Cheverly	14	Prince George's
			Prince George's Hospital Center		8 Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or
	neral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last bli	Months Days Hours Min		Foreign
Dire	ctor	L	578-88-8621 1 XM 2 F 36	Yrs.	02/16/1	971 cowash., DC
		4. 9	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	0 W 2			Silver Spring		1 X Yes 2 No
yland	28a-f show any d at once.	형	Maryland Prince George's	10f. Zip Code	10g. (Citizen of What Country?
e Mai	23a or 28a-f sho notified at once.	Director	8405 Navahoe Drive	20903	2 00	United States
vith th	s 23a e noti		11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
eath v	items ust be	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Kican, etc.)	
fter d	l", or	by Fi	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Black b. Kind of Business/Industry
ours a	xami		15. Decedent's Education (opean) only managed at the	 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re 		D. Killy of Business/illustry
6 172 h	an "ns ical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	Communication	n	Private
215-0036 be filed within 7	other than other Medical	E.	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Surname)
15- filed	ed of	Be C	Author I Ionas		Doris	J. Dukes
212	mark c ever	0	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or		
MD ad 2 sho	h and 27 is imati	-	Celeste Jones/Sister	4223 First St., S.	E #202, Wa	oc. Location - City or Town, State
	Healt item	ı	crem	e of Disposition (Name of cemetery, natory or other place)	Date 2	oc. Location - Sity of Towns, State
nor	nt: If	- 1			/18/2007	Wash. DC
Baltimore,	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee			ineral Home
m a	iii II De		John J. Sleval III	4001 Benning R	d., NE Wa	shock or heart Approximate Interval
	sician		23a. Pat/1. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	A A	or respiratory arrest	Between Onset and Death
	edical miner		Immediate Cause (Final disease or condition resulting in death) a Gunshot Wound Of The Country of the Country	Chest		
			h			
		ler	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated Disease Original Disease or injury that initiated Disease Original Disease or injury that initiated Disease Original D			
ited	d ansit		events resulting in death) Last Due to (or as a consequence or).			
Division of Vital Records, P.O. Box 68760, the Brosial or Attending Physician: The law requires that the death certificate be executed	ysician and burial - transit	Medical	UNPENDED AMENDED			
60, ate be	physician he burial	Med	IF FEMALE: 23c. If yes, outcome of pregnar			23d. Date of delivery Month Day Year
687 ertific	ding p		23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pres	gnancy	World Bay
Box 687 e death certific	e attending for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		
. 	by the	H	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
P.C	signed by the	Completed by	Blunt force head injuries			2 No 3 Probably 4 Unknown
rds, requir	has been s 2 should	ete			24a. Was ar autops	y prior to completion of cause of
COI e law	e has	립			perform 1 ✓ Yes 2	
8 =	tificat or, pa	ပို	25. Was case referred to medical	26.Place of Death (Che	ck only one)	
Division of Vital Records, P.O.	this certificate I director, page) B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VE	TO COLPANION TO THE TOTAL TOTAL TO THE TOTAL TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE	•	Residence 6 Other:
of of	After th	۱ř	27 Manner of Death 28a, Date of Injury 2	28c. Injury at Work? 324 hrs 1 Yes 2 No.	Subject was	ow injury occurred shot and struck on the head
on	eath. Ior: / the fi	atio	Natural 5 Pending Jun 9, 2007 Accident Investigation		Off Leasting (St	treet and Number or Rural Route Number, City
vis	ofter d	Li i	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office building, etc.	or Town St	ate) Parkway, Suitland, MD
	neral filled	Certification:	4 V Homicide determined (Specify) Apartment B			
- Ho	within 24 burneral Birector; After this certificate from lefe Funeral Director; After this certificate from lefely filled in by the funeral director, page	हु	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To th	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		-	that garlle 11 and	O.C.M.E.		June 9, 2007
/		1	30 Name and address of person who completed cause of death (Item 2	23a)		
R G	4		Pamela E. Southall, MD Assistant Medical Exam	niner 111 Penn Street, Baltimor	e, MD 21201	
1		State	31. Date filed (Month, Day Year) 32. Registrar's Signatur	e di		
		etra	111N 1 5 2007 Factor D. P.			

07-04783 Kathryn Ann Jud	łd_T				int in B faryland								jible.		
		1- For State Registrar 1. Decedent's Nan			iai yiai iu		rtificate						g. No.	20	7 212
Physici Medical Exami		Kathryn	Ann J	udd-Ti							I.	fonth Jne 23, 2	Day 007	Year	3. Time of Death 1417 hrs
ž.		4a. Facility Name		on, give stree	t and number)			, Town, or tonsville	Location of	Death			County of Deat ontgomery	h
Funeral Director		5. Social Security		6. Sex		ge (In yrs. I	ast birthday		nder 1 Yea		24Hrs. 8.	Date of Birt	h(MM/D	Forei	
		216-40-8 Usual Residence		1 M 2	2 X F		62	Yrs.			C	ct 31	, 19)44 C	ountry) MD
a any		10a. State	10b. County			,	Town or Lo								10d. Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho	Director	MD 10e. Street and Nu	Montgo	omery		Burt	onsvi.		Zip Code			10	g. Citize	en of What Cou	untry?
ith the ?		3113 Win	ifred 1		Was Deceden	t Ever in II	e 112		866	panic Origin	n2 (Specifi		USA	A Pace - Ame	rican Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Marr		Married A	Armed Forces Yes 2					, Mexican, F				White, etc.	ncan indian, black,
2 hours after "natural", c	by	3 Widowed 15. Decedent's E		vorced If Yes, or Date ecify only high	Give Year les:		1 16a. Dece		2 X No	specify:	nd of work	done		pecify: Wha	
	Completed	Elementary/Sec			ollege (1-4 or		durin	g most of v	working life	. DO NOT us		2.		1,0	
21215-0036 uld be filed within 77 Mental Hygiene. marked other than	Somp	17. Father's Name	(First, Middle	e, Last)	2	-	Accou	ıntan		18.Mother's	Name (Fire	st, Middle, M		ounting	g Firm
D 21215 should be file and Mental H 7 is marked on natic event, the	o Be (Joseph J.					405 14-	A dd		Tilli		_		or Town, Stat	7.01
y, MD 212 and 2 should be lealth and Menta tem 27 is marke traumatic even	-	Stuart K.			rint)					Rd.					e, Zip Code)
2		20a. Method of Dis	position X Crematio	n 3 🗌 Re	moval from S	tate	Place of Dis crematory o	other place	ce)	,	Da	-	20c. Lo	ocation - City o	r Town, State
Baltimor permit. Pages Department of Important: If		4 Donation 5	Other S		1,	Ch	esapea 2							tsville	Box 784
0		Devel	11	telt	tto	MO1									BOX / 84 11
Physician /Medical		failure, List of	nly one cause	on each line						,	rolac or res	piratory arre	St, Snoc	k, or neart	Between Onset and Death
Examiner		or condition result			(or as a cons			Caraca Ca							
	iner	Sequentially list co if any, leading to in cause. Enter Und	mmediate		(or as a cons	equence o	f):								
cecuted r and - transit	l Examiner	(Disease or injury events resulting in	that initiated death) Last	C	(or as a cons	equence o	f):								
e e e;	edical	X UNPENDED)		23a,27,p			27/07	TT						
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be extalter death. al Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent past 12 month	s?		Live birth Pregnant a		2	Fetal dea Other (S)		Ectopic p	pregnancy			Date of deliver Month	ry Day Year
the death	Phys	1 Yes 2		tions contri	Unknown	th but not re	esulting in th			iven in Part	1	23e. Did to	bacco us	se contribute to	the cause of death?
, P.C ires that signed to be deta	þ				Dating to doo									No 3 Pro	
ords aw requisas been 2 should	Completed											24a. Was a autops perfor	sy		utopsy findings available completion of cause of
Rec r: The l tiffcate b		25. Was case refe	red to medic	al					26 Place	of Death (C	heck only	1 Yes 2		1 🗸 Y	es 2 No
Vital hysician this cer	ro Be	examiner?	2 No	Hospita	l: 1 Inpati	ent 2	ER/Outpati	ent 3	DOA	Other:	Nursing Ho		Residen	ce 6 🗸 Othe	er: Scene
on of nding P th. :: After e funera	ion: T	27. Manner of Dea		ding 28	Ba. Date of Inj (Month, Day,		28b. Time	of Injury		ryat Work? ∕es 2 N		. Describe h	ow injur	y occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	2 Accident 3 Suicide	Inve	stigation	8e. Place of I	njury - At h	ome, farm, s	treet, facto	ory, office b	uilding, etc.	. 28f.	Location (S or Town, St		d Number or R	ural Route Number, City
Di Hospital 24 hours a Funeral		4 Homicide 29a. Certifier			Specify)	na kanauda d	as dooth as	austrad at 1	the time de	to and place	a and due			mannar ac eta	tod
To the F within 24 To the F complete	Medical	(Check only one) 2 ✓		miner:On th		mination a	_							manner as sta e, and due to t	
	Σ	29b. Signature and	1 - 1	er	(0.11			2	29c. Licens O.C.I					ate signed (Mo 24, 2007	onth, Day, Year)
2)02		30. Name and add	ress of person	who comple	ted cause of	death (Item	23a)								
	nte.	Margarita K			nt Medica			Penn S	Street, B	altimore,	MD 212	01			
Regist	ate trar			7 2007	Blue	Le o Orginale	K A	host	5						

State Registrar DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KIRSCHBAUM S. JUNE 15, 12:30 PM FRANCES 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 K) F JUNE 19, 1908 AUSTRIA Director 054-09-6350 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County iteme 23a or 28e-f ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director ROCKVILLE MD MONTGOMERY 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code **USA** 20852 6105 MONTROSE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ò Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT CLERK US GOVERNMENT 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental ANNA DOSIK GEORGE SAGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any i jury or other treu 6326 CROSSWOODS DR., FALLS CHURCH, VA 22044 IRA KIRSCHBAUM - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State MT. LEBANON CEMETERY 6/17/2007 ADELPHI. MD 4 ☐ Donation 5 ☐ Other (Specify) 9 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ARLINGTON FUNERAL HOME 3901 N. FAIRFAX DR., ARLINGTON, VA 22203 Edew Approximate
Interval Between
Onset and Death
5 day (23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COMAESTIVE HEART dans /Medical Due to (or as a consequence of): Examiner orter DEDWARM weard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons - uence of): Examiner burial-transit and resulting in death) Last Due to (or as a consequence of) Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dheumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Lirschbanm of Vital Records, P.O. Physician: Attending Division death.

with the Maryland

To the Funerel Director: After the completely filled in by the funeral To the Hospital o within 24 hours af To the Funerel D

Registrar

31. Date filed (Month, Day, Year) JUN 18 2007 State

2 Accident

3 Suicide

29a Certifier

4 Homicide

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nho m

5 Pending investigation

6 ☐ Could not be

ertifie

Montrose 612 32. Aegistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number m037

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			For State	State	of Marylan	•	artment of H		nd Mer		ene 1. No.		i t	~ ·
			Registrar 1. Decedent's Name (First, Middle	, Last)		001	timouto or i	Journ		Date of Death		1	3. Time of	Death
	Physicia			Francis	Luswa Li	uvimba:	zi.			ine 14,	2007 Y	rear	4:45	A M
	/Medic Examin	2	4a. Facility Name (If not institution				4b. City, Town, or	r Location of			4c. County of			
J.			Montgomery Hos					ville				gome		
	Funeral	3	5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, 1 Ine 3, 1	rear)	Country		or Foreign
	Director		None Usual Residence of Decedent		77	110.			μu	ine 3, I	930	Ug	anda	
	yland iow at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation		_			100	d. Inside Ci	
	a-f sh ifled	cto	Maryland Montg	omery			Silve	r Spri	ing				1 ☐ Yes	2 X No
	or 28	Directo	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh		y?	
	ath w	la l	14302 Trillium					20906				ında	- Indian	
	er de Items	Funeral	11. Marital Status 1 □ Never Married 2 X Marr	Armed F	cedent Ever in U. Forces? : 2 🔀 No	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origi an, Mexican,	Puerto Ric	y Yes or No- an, etc.)	14. Race - Black,	White, et		
20	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	aive		1 ☐ Yes 2 ☑ No	Specify:			Specify:	B1	Lack	
2-003p	72 hours after death with the Maryland natural", or Items 23a or 28a-f show iteal Examiner must be notified at		15. Deceden (Specify only higher	t's Education	n	16a. Dece	dent's Usual Occup	ation	of working	10	6b. Kind of Busi	ness/Indu	stry	
7	thin 7 ie. ian "r Me	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	kind of work done DO NOT use retired		or working		_			
7	ed wi ygien ner th	Co			5+	Rese	arch Ecor		la Nama /f	tona Baladada Bal	Econom			
and	Ibe fil ntal H ed ott	Be	17. Father's Name (First, Middle, Peter Tebukya	Last)					y Naly		aiden Surname)	,		
Ĕ	hould d Me mark matic	ည	19a. Informant's Name/Relations	nin (Type, Print)		19b. Mailir	na Address (Street		<u> </u>		City or Town. S	tate. Zip C	2ode)	
Z Z	nd 2 s Ilth an 127 is rtrau		Jacqueline Kiwa		ohter		2 Trillium			,	,		·	0906
อ์	f Hear Item		20a. Method of Disposition		20b. F		osition (Name of matory or other place		Date	. 2	Oc. Location - C PIGI Di			
Ē	Page nent o int: if iry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		rial Gro	, 0 1	une 24 200		itulo Vi			anda
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygien. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Me I cal Examiner must be notifiled at once.		21. Signature of Funeral Service	Licensee	12 00.	R	2. Name and Addre obert A. 00 West Mc	ss of Facility						
מ	50 E E E		My		M00									
			23a. Part1. Enter the disease, or shock, or heart failure. List			h. Do not en	ter the mode of dyir	ng, such as c	cardiac or re	espiratory arres	st,	í	Approximat Interval Bet Onset and	te tween Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		ncer of		ctum							
-	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	quence of):								
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conseq	quence of):						-		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events											
Ď	be executed ician and burial-transit		resulting in death) Last	CDue to	o (or as a conseq	juence of):								
8/PU	cate be executed hysician and the burial-transit	lical		d										
Õ	death certificate e attending phys d for use as the	ä	IF FEMALE:											
X Q Q	ath catherd	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	outcome pf pregna birth 2 Feta gnant at time of c	al death 3	☐Ectopic pregnancy	У			23d. Date Mont		•	Year
o	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk		ieam 5L	Other (specify)							
ž.	w requires that the de been signed by the should be detached		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	inderlying cause giv	en in Part I.		23e. Did toba	acco use contrib	oute to the	cause of	death?
rds	quires n sigr ald be	d by								1 ☐ Yes	s 2 □ No 3	3 ☐ Proba	bly 4 🏋	Unknown
ecord	law rec as bee 2 shot	Completed							Î	24a. Was an	24b. W	ere autop:	sy findings	available
Ĭ	The la	mo							_	autopsy perform 1☐ Yes 2	ed? de	eath?	ıpletion of α 2∐ No	ause of
VITAI H	ysician: The lav is certificate has director, page 2	Be C	25. Was case referred to medica examiner?					26. Place	of Death (C	Check only one	4.5			
_	Sir dij	မ	1 ☐ Yes 2 ☑ No		Inpatient 2	-		4 🗆 Nur			nce 6 X Other		Hos	oice
<u> </u>	ling P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	g (Mo	te of Injury onth, Day Year)	28b. Time o Injury	Wor	ryat nk? ∣Yes 2.∐N		Describe hov	v injury occurre	d		
VISION	death death ctor: y the	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be 280 Plan	ce of injury - At h	ome, farm, st	reet, factory, office	163 201		. Location (Stre	eet and Number	r or Rural	Route Nur	mber,
2	after after I Dire d in by	Certification:	4 ☐ Homicide determ	ined buil	lding, etc. (Speci	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,				ŕ
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examina									s)
	o the ithin 2 o the comple	Medical	29b. Signature and title of certifie		anner stated.	`	29c. Licens	se number		29	d. Date signed	(Month, D	Day, Year)	-
\	ĕ∓ĕ≒		100 minus /	In All	rek u	11)	Dog	064	615		June 15			
	15		30. Name and address of person	who completed ca	iuse of death (Iter	m 23a) (Type.	Print)		-					
			Genevieve Wrob	lewski, l	M.D. 600	1 Munc	aster Mi	ll Roa	d, Ro	ckville	e, Mary	Land	2085	55
	Sta Registi		31. Date filed (Month, Day, Year)	32.	Bigistrar's Sign	ature A	and i							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hydiene

		1. Decedent's Name (First, M	iddle, Last)		ertificate of	Dodin		eg. No.		
Phys /Me			Milton A	braham LAIT	MAN		2. Date of Deat Month	Day	Year	3. Time of Death
Exan		A CONTRACTOR OF THE PARTY OF TH	ition, give street and numb	er)	4b. City, Town, o	r Location of Des	June 15	<u> </u>		4:30 P M
		11913 Reynold	s Avenue		Potomac	r Essention of Des	ute i		y of Death tgom e	rv
Funera		5. Social Security Number	6. Sex 7. 1 → M 2 → F	Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of Birth			lace (State or Foreign
irecto	r	119-01-3740 Usual Residence of Decedent	44	90 Yrs.	Months	Hours Mir	June 7,	1917	New	York
Mo H		10a. State 10b. Cou		10c. City, Town or L	ocation					
netural', or iteme 23a or 28a-f ehow Istal Examiner roust be notified at	į	Maryland Mon	tgomery	Potomac					1	0d. Inside City Limits 1 ☐ Yes 2 ➡ No
Or 40	J. P.	10e. Street and Number	<u> </u>	1000114	10f. Zip Code		10	Og. Citizen of	Mhat Caus	21
1 2 2	6	11913 Reynold	s Avenue			20854		Unite		•
a di	Funeral Director	11. Marital Status	12. Was Deceder Amed Force	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-	14. Rac	e - Americ	an Indian.
THE STREET	bv F	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorce	arned 1 Yes 2 If Yes, Give		1 ☐ Yes 2X No		to Rican, etc.)	Blac	ck, White, e	etc.
	be	15 Deced	ent's Education	. MM II				Specify	/: Wn	ite
	Completed	(Specify only high	hest grade completed)	(GIVA	dent's Usual Occupa kind of work done o DO NOT use retired	ition Juring most of wo	rking 1	6b. Kind of Bu	usiness/Ind	lustry
	É	Elementary/Secondary (0-12	College (1-40)	1 37)	Resource			n - J 1		
event,	Be	17. Father's Name (First, Middle	e, Last)		Resource		ne (First, Middle, M			ernment
BIIC	2	Jacol	Laitman			Rose Bu		aiden Sumam	ιθ)	
		19a. Informant's Name/Relatio	nship (Type, Print)	19b. Mailir	g Address (Street a	nd Number or Ru	Iral Boute Number	City or Town	State Zie	Codol
		Harriet F. Lai	tman, Wife	11913	Reynolds	Avenue	Potomac	, MD 2	20854	200e)
eny injury or other traumatic e once.		20a. Method of Disposition 1XD Burial 2 ☐ Cremation	1 3 ⊠Removal from State	20b. Place of Dispo	sition (Name of natory or other place	,	Date 20	Oc. Location -	City or Tow	m, State
		4 □ Donation 5 □ Other	(Specify)	Beth Davi			0/07	.1	****	
S C		21. Signature of Funeral Service	e Licensee	Tô	Name and Address	Hebrew I	uneral Ho	Elmont,	MA	
		200 0 111 5	<	- 125	4 Carroll	C+ NT	7 771- 1		nc 20	0012
		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cause st only one cause on each I	d the death. Do not ente ine.	r the mode of dying	such as cardiac	or respiratory arres	t,	1	Approximate
an		Immediate Cause (Final disease or condition resulting in death)	a BR	ONCHIE	TASIS					nterval Between Onset and Death
cal ter		resulting in death)	Due to (or as	a consequence of):	-11)-13					
	-	Sequentially list conditions.	b							
	i i	Sequentially list conditions. If any leading to immodute cause. Enter Underlying Cause (Disease or injury that included and included a	Due to (or as	а сопъедиенье оту:						
	Examiner	that initiated events resulting in death) Last	C. Due to (or so	a consequence of):						
	alE		505 to (0) as	a consequence of):					= -	
	Medical		d.		_					
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				1		
	icia	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death 3 E	ctopic pregnancy				of delivery	
	hysician/	9 Unknown	9□ Unknown	Si dealii 5	Other (specify)			Mont	ıı Da	ay Year
	by P	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the unc	lerlying cause given	in Part I	23e Did tobac	00 1180 00=1:1	uito to ::	
					g an		1 Tes	_		cause of death?
	piet								Probabl	A
	Completed						24a. Was an autopsy	DIR	or to combi	findings available letion of cause of
	0	25. Was case referred to medica					performed 1 ☐ Yes 2 ☐	r dea	ath? Yes 2	
	ල ව	examiner? 1 ☐ Yes 2 💆 No	Hospital:	2058/0	2 Other	6. Place of Death	(Check only one)			
	n: T	27. Manner of Death	28a. Date of Injur	y 28b. Time of	3 DOA 28c. Injury at	4 Nursing Hor	me 5 Residence	6 ☐Other	(Specify)	
	atic	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, Day	Year) Injury	Work?	2 □ No	28d. Describe how in	njury occurred		
	Certification:	3 ☐ Suicide 6 ☐ Could of determ	ined 286. Place of Inju	ry - At home, farm, stree			Rf Location /Chr	and Alice to	n= D: = 15	
			building, etc	. (Specify)		-	28f. Location (Street City or Town, St	and Number ate)	or Hural Ro	oute Number,
		29a. Certifier (Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	f my knowledge, death o	ocurred at the time	date and place of	nd due to the	(a) as d		
1	fedicai		Examiner: On the basis of and manner stat	examination and/or invested.	tigation, in my opini	on, death occurre	ed at the time, date a	e(s) and manna and place, and	er as stated due to the	d. P cause(s)
		29b. Signature and title of certifier			29c. License nu			Date signed (A		
			1 1/1 1/		D 265	71				
	L					/ .1.	, III	me in	2.007	1
,	:	30. Name and address of person v	mo completed cause of de	ath (Item 23a) (Type, Pri		/ 1	Ju	me 15,	2007	
Stat		30. Name and address of person of the state	V	oncord Stre	nt)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Marie Theresa Lawson 4 2007 11:20 A. /Medical 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 151-50-7121 9/11/1954 Director 52 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notified a 1 □Yes 2XNo MD Carroll Hampstead Director the I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 909 Century Street 21074 United States ns 23a c must b by Funeral Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced "natural" Completed er than "natur the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residence Homemaker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Monteferrante John Babiasz, Sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trainonce. Edward Johnathan Lawson-Husband 909 Century Street Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 6/16/2007 Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 21. Signature of Funeral Service Licenser M01490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician esmirator /Medical Due to (or as a o nsequence of): Examiner robable Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 co/0 4 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the sirector, page 2 s perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wher (Specify) In patient Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred after death.

I Director: After to din by the funeral 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 6/15/07 15552 WIL , M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St. Westminster, Md. 21157 Saiontz 555 M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 8 2007 Registrar

			_	Type or Prin State of Ma						_		_	e.	
			1 - State Registrar		,				Death	,	Reg. No			21237
0		П	1. Decedent's Name (First, Middle, Las	it)		 -		_		2. Date of D Month	eath Da	av V	ear	3. Time of Death
	Physicia /Medic		Carroll			Lo	gue			June :	13 , ິ	2007	cai	5:30 p ^M
	Examin		4a. Facility Name (If not institution, give	street and number)				1	Location of Death		40	c. County of		
	and the same of the		Dove House Hospi		4				nster If Under 24 Hrs.	T . D		Carro		(0)
	Funeral	ļ	5. Social Security Number 6. S	ex 7. Age MIM 2□F	e (In yrs. 1 82	last birthday) Yrs.	Months	1 Year Days	Hours Min.	8. Date of Bi (Month, D June	rth ay, <i>Year</i> 101	925	. Birthpi Coun	lace (State or Foreign try) MD
	Director		215-20-9952 Usual Residence of Decedent		02					oure	12 1	.923		T-IL-
ylan	now at		10a. State 10b. County		10c. City	y, Town or Loc	cation						1	0d. Inside City Limits
Ma	3a-f s	Director	Maryland Carrol	1	5	Smallwo	od							1 ☐ Yes 2 ŽÑNo
ŧ	or 28	Dire	10e. Street and Number	2			10f. Zip				10g. C	itizen of Wha	at Coun	try?
t d	s 23a	ra	715 Deer Park Ro		Cura in III	C 112 W	Man Dana	211		negify Ven er N		USA 14. Race -	Americ	an Indian
or of	Item Iner n	Funeral	11. Marital Status 1 ☐ Never Married 2X Married	12. Was Decedent I Armed Forces? 1 XYes 2 □ N	No.		f Yes, spe	cify Cuba	spanic Origin? (S n, Mexican, Puert	o Rican, etc.)	0-		White,	
	al", or ∷xa⊞i	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1952 1	I □ Yes	2 X No	Specify:			Specify:	W	hite
ING Z I Z I 3-0030 he filed within 72 hours effer death with the Mandand	atura ical E	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	lent's Usu	al Occupa	ation	kina	16b. I	Kind of Busir	ness/Inc	lustry
7 Light	e. Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)				during most of wor)	KIIIG		7 6	1	
7	lygien her th nt, the	S	7				usto	dian	40. Mathada Nas	on (First Adiabet			Eau	cation
	ad oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nan		e, Maide	n Surname)		
	d Mel marke	2	Elmer F. Logue 19a. Informant's Name/Relationship (Type Print)		19h Mailin	a Address	Street a	Annie I		ber City	or Town St	ate Zin	Code)
	than 17 is i			wife			•			Westmin				
v -	Hea tem 2		Hilda Logue 20a. Method of Disposition	wire	20b. F	Place of Dispos cemetery, cren	sition (Na	me of		Date		ocation - Ci		
9 E	ent of		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			er Park				3/2007	Gam	ber, N	/ary	land
	penium. Tagger leads a should be med water to be a second with the penium of the peniu		21. Signature of Funeral Service Licer			22	. Name a	nd Addres	ss of Facility Pr	itts Fu	nera	1 Home	. & ∈	Chapel, PA
0 3	B a L a		Kyphin K 78	4		41	2 Wa	shine	gton Rd.	Westmi	nste			.157
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the deatl	h. Do not ente	er the mo	de of dyin	g, such as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
100	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Ca	nde	agem	C	21	wek					Onsor and Bodan
	/Medical xaminer		resulting in death)	Due to (or as		uende of): MULC	(200	hvek lis my	nobal	Mh.			
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as									+	
Pot	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0										
500 ,	an an rial-tr		resulting in death) Last	Due to (or as	a conseq	uence of):								
0/0	hysici he bu	Physician/Medical	•	d										
X OO	ing pl	Med	IF FEMALE:	20. 15										
ב ב	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	il death 3 □	Ectopic p					23d. Date of Month		ery Day Year
j	/ the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	time or d	leatii 5L	10ther (a	pedity)						
L to	ned by		Part II. Other significant conditions	ontributing to death b	ut not res	ulting in the ur	nderlying	cause give	en in Part I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
ecords,	an sign	ed by								1 🗆] Yes	2 □ No 3	☐ Prob	pably 4 Onknown
	aw le	Completed								24a. Wa	s an opsy	24b. We	ere auto	psy findings available mpletion of cause of
	ate ha	mo								per 1∐ Yes	formed?	dea	ath?	2□ No
VILC	ertifica ctor,	BeC	25. Was case referred to medical examiner?						26. Place of Dea	ath (Check only	one)			
) V	this co	70.	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		ER/Outpatien			4 Li Nursing F					in Hospice
DIVISION OF	After	on:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	м	28c. Injur Worl	yat k? Yes 2∐No	28d. Describe	how inj	ury occurred	ı	*
	death ctor: y the i	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		urv - At ho	ome. farm. stre			162 5 140	28f. Location	(Street a	and Number	or Rura	al Route Number,
	after Dire	Certification:	4 ☐ Homicide determined	28e. Place of injusting, et	c. (Specif	(y)		,,		City or T	own, Sta	ite)		
- ing	hours neral y filler			ysician: To the best										
, i	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	niner: On the basis o and manner sta		ation and/or in	-		•					
Š	T COUNTY	2	29b. Signature and title of certifier	10	1 0		29	c. Licens	9 number	mn	29d. D	ate signed (Month,	Day, Year)
	9x11		mar	vor	()			U	2-1707	J		011	11	
	· Cur		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type, I	Print)	£7,	East	Main	St,	West	Huy	Day, Year) 7 intenty 2115)
秀一	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr		<u> </u>		. (21157
	Registi	rar	IIIN 15	2007		H	1							

			1 - For State Amei	nd #7 8	State 48, 6- 1	of Ma L 9-07	ryland, per	/ Depa	rtment HCHD Vilicate	of He	ealth a Death	and M	ental Hy	giene Reg. No.	20	17	212	3)
ſ	Physici /Medic		1. Decedent's Name DOLORIS	First, Middle	e, Last)	OOPER							2. Date of De Month JUNE			2 ^Y 007	3. Time of D	eath P M
	Examin		4a, Facility Name (If	not institution	, give street and r	number)			4b. City, To	own, or L	Location o	of Death		4c.	County	of Death		
			FREDER:		EMORIAL	HOSP				EDER		0411			REDI	ERICK		
ı	Funeral Director		5. Social Security No. 264-36-08		6. Sex 1 ☐ M 2 🂢 F	7. Age	(In yrs. last	t birthday) Yrs.	If Under 1 Months	Days	If Under: Hours	Min	8. Date of Bir (Month, Da Jan 3	rth a <i>y, Year)</i> 1928	8-	9. Birthpl Coun. Flor	ace <i>(State or F</i> ty) ida	Foreign
	σ		Usual Residence of										Jan 3		29			
	anyfar show	_	10a. State	10b. County			10c. City, T	own or Lo	cation							10	d. Inside City	
	ne Ma Ba-f s	cto	MD	Freder	ick]	New Ma	arket									1 Yes 2	X No
	with the part of the part	Funeral Director	10e. Street and Nun 10295 P1a		ace				10f. Zip C					10g. Citiz	zen of V	Vhat Coun	try?	
	death ms 2%	nera	11. Marital Status		12. Was De	cedent E	ver in U.S.	13. \		·	panic Ori	gin? (Spec	cify Yes or No Rican, etc.)			e - America		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M. dical Examiner must be notified at once.	by	1 ☐ Never Marri 3 📉 Widowed	_	ed 1 Yes, (s 2 ⊠ No Give	D		Yes 2	_	Specify:	i, Puerto F	(ican, etc.)		Specify	k, White, o		
2-0	72 ho natur dical i	eted	(Spec	15. Decedent	's Education of grade completed	d)] 1	6a. Deced	lent's Usual	Occupat	tion uring most	t of workin	a	16b. Kir	nd of Bu	usiness/Ind	ustry	
121	within ene. than "	Completed	Elementary/Secon		1	(1-4or 5+			kind of work 00 NOT use 1 Ager		, mg moo	. 01 11017777	9	Tra	₁₇₀ 1			
2	filed v Hygie other i	ပ္ပ	17. Father's Name (First, Middle,	Last)	+		liave	1 Agei		18. Mothe	r's Name	(First, Middle			ne)		
Maryland	ald be fental rked c	To Be	Leslie Cl	ayton	Bortle						Flore	ence	Marie	Hass		•		
ary	shou and N s ma		19a. Informant's Na	me/Relationsl	nip (Type. Print)		1	19b. Mailin	g Address (Street ar	nd Numbe	er or Rural	Route Numb	er, City or	r Town,	State, Zip	Code)	
Σ,	and and marker and marker tra	5 11	Pamela L.		lkner/da	ught					lace		Marke					
Ore	ges 1 It of H If itel		20a. Method of Disp 1 ☐ Burial 2 🖁		3 □Removal from	m State	cem	etery, cren	sition (Name natory or oth	er place,			ate /o.=			City or To		
Baltimore,	it. Pa irtmen irtant: njury		4 □ Donation		-	//	Chesa		e Cren		- ;	06/19				lle, l		
Ba	Depa Impo any I		21. Signature of Full	ve I I	Hold	L	MO12						Servi				784 MD 21	029
	110		23a. Part1. Enter the shock, or hear	ne dis se, or rt failure. List	complications tha only one cause or	t caused to each line	he death. E	Do not ente	er the mode	of dying,	, such as	cardiac or	respiratory a	irrest,			Approximate Interval Betwe	en
	Physician		Immediate Cause (I disease or condition resulting in death)	Final 1	a.	(VA										Onset and De	ath
	/Medical Examiner		resulting in death)		Duet	o (or as a	consequen	ice of):										
		ē	Sequentially list con if any, leading to im cause. Enter Under	nditions, mediate	b. Due t	o (or as a	consequen	ce of):										
	cuted nd ransit	Examiner	that initiated events	injury	C.													
Ő,	icate be executed physician and s the burial-transit	EX	resulting in death) L	ast	Due t	o (or as a	consequen	ce of):										
8760,	cate b	dical			d							-						
Box 6	eath certific attending p for use as	Φ 1	IF FEMALE:	prospert	23c. If yes, c	utcome p	f pregnancy	/							23d Dat	e of delive	2/	
.O.	o o	ysician/M	23b. Was decedent in the past 12 i 1 ☐ Yes 2 🕏 9 ☐ Unknown	menths?	1 □ Live	birth 2 gnant at ti	Fetal de ime of death	ath 3□	Ectopic preg Other (spec						Moi		Day Ye	ar
Δ.	s that ned by e deta	by Phys	Part II. Other signifi	cant condition	ns contributing to	death but	not resultin	g in the un	derlying cau	se given	n in Part I.		23e. Did 1	tobacco u	se contr	ribute to th	e cause of dea	ath?
ords	w requires that been signed I should be det	ted b											1 🗆	Yes 2	□No	3 ☐ Proba	ably 4 □Uni	known
l Records,		Completed											24a. Was auto perio			Were autop prior to con death? □ □ Yes	sy findings ava pletion of cau 2 □ No	ailable se of
Vita	Physician: r this certific ral director,	Be	25. Was case referrexaminer?	ed to medical								of Death	(Check only o	•				
or	Physical this call dire	P	1 Yes 2			Inpatien		Outpatien		Other	4 🗀 N0		e 5□Resi)	
on	Ilng Afte une	tion:	1 Natural	5 ☐ Pending investig) (Mo	e of Injury onth, Day		b. Time of Injury	M 280	lnjury a Work?	at es 2⊡1		3d. Describe	how injury	y occurr	ed		
Division or	il or Attending after death. I Director: After d in by the fune	fica	2 Accident 3 Suicide	6 Could n	ot be 28e. Place	ce of injur	y - At home,	, farm, stre	et, factory, o		00 2		Bf. Location (Street and	d Numbe	er or Rurai	Route Numbe	e <i>r</i> ,
á	tal or is afte al Dir	Certification:	4 ☐ Homicide		buil	lding, etc.	(Specify)						City or To	wn, State))			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	edical	29a. Certifier (Check only one)	CertifyIng	g Physiclan: To to Examiner: On the and ma	he best of basis of e anner state	examination	dge, death and/or inv	occurred at restigation, in	the time n my opi	e, date an inion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and ma I place, a	nner as stand due to	ated. the cause(s)	
	withi To th	M	29b. Signature and	title of certifier	112/0				29c. l	icense r	number			29d. Date	e signed	d (Month, L	Day, Year)	
) _			-> ha	isan 0	119 FLOS	PITA	UST		1311	965	140	10	6	10/0)	4:	copm	
6) By		30. Name and addre	ess of person v	who completed ca	11	ath (Item 23		Print) 400 L	υ, -	7th	5+ 1	rederin	Kn	20	2170	/	
	Sta Registra		31. Date filed (Monti	h, Day, Year) JUN 1	32.		's Signature		/					-/-				
	nogisti			OIL T	, 2001	-	2	· A	me									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Month **Physician** June 16, 0250 A Patricia Ann Lasecki /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 24, Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Pennsylvania ĩ 944 Director 191-34-2465 62 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director Tannersville PA Monroe 10e. Street and Number 10q. Citizen of What Country? 10f, Zip Code 18372 USA 806 Twin Oak Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Terplevitz John Dzialdowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8420 Cherry Laurel Court Laurel, MD 20723 Matthew Lasecki/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 06/19/07 Beltsville, MD 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUITIPIT unn (disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) inel death certificate be executed as the burial-transit Exami and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9☐ Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown should should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has le 2 autopsy page performe es 2 certificate 2□ No 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Nospile Hospital: 1 ☐ Yes - 2 No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Jeath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 Pending investigation To the nospon... within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST

Registrar DHMH 17 Rev 1/2001

State

CHANGES

JUN 1 9 2007

31. Date filed (Month, Day, Year)

W

Raistrar's Signature

ANG, DANIEL

1	ı
	í
-	
Box 68760	
<u></u>	
88	
×	-
Ô	
$\mathbf{\omega}$	
o.	
\sim	1
ш	;
Ś	
5	
0	
9	
Œ	
<u>—</u>	1
ij	
>	
5	
2	
0	:
· <u>S</u>	ŧ
.2	
Division or Vital Records, P.O. F	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year -Month **Physician** 8:334M Tune , 2007 Daniel Lee Lang 12 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days XXM 2□F Director 294-34-5921 67 July 13, 1939 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a. State a or 28a-f show be notified at 28a-f show 1 X Yes 2 No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Funeral 20715 USA 12107 Maycheck Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 158-162 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: if Item 27 is marked other the any injury or other traumatic event, the J once. Writer Public Relations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Kuziak Roy Lew Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12107 Maycheck Lane Bowie, MD 20715 Joyce Francine Lang/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Cathol
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/18/2007 | Bowie, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXIA Physician /Medical Due to (or as a consequence of): Examiner ULMONARY Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a porisequence. If Examiner the burial-tran and Due to (or as a consequence of): attending physician for use as the buriet Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) i signed by the aid be detached f 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Hospital: 1 ☐ Inpatient 2 ☐ PA/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 61437 30, Name and address of person who empleted cause of death (Item 23a) (Type, Print) 575 Main Street, Suito 351, Laurel, m.D. 20707 ameo 31. Date filed (Month. Da State JUN 1 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 14:00P M LEE ETHAN 18 2007 /Medical 4c. County of Death Facility Name (If pet institution, give 4b. City, Town, or Location of Death Examiner GROVE HOSPITAL KOCKVILL HOUENTIST MONTGOMERY Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 06 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2□F JONE 2007 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No MONTGOMERY ARKSBURG, MARYLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number CLARKSMEAD DRIVE#303 20871 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ASIAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER 23730 CLARKSMEAD DRIVE #303, CLARKSBURGMO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/18/2007 HALL RIVER, NC STERI CYCLE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Auneral Service Licer 9901 MEDICAL CENTER DR, ROCKVILLE MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VERE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours a 'er death. To the Funeral Director: After this certificate h 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

KALPANA HELMBRE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

CTH, MD, 32. Registrar's Signature

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD

29c. License number

DO059166

29d. Date signed (Month, Day, Year)

06/18/2007

			Plea	se Type or					ble Ink. ent of H					_	ible.		
		For State AMEN	#23A,Pt.	1&Pt.2,per	4D,6/	/18/07 ,	DPS (M	P Dific	cate of L	Death	aria iv	icitaii	Reg.	-	4-7	0) 1	010
		Necedent's Nam	ne (First, Middl	e, Last)								2. Date of		h-3		3. Time of	Death
Physicia /Medic		LAIDLER	BOWII	E MACKAL	L							JUNE	6.	Day 2007	Year	8:30	P M
Examin		4a. Facility Name (umber)			4b. (City, Town, or	Location	of Death				y of Death		
				ARK DRIVE					HEVY CH						GOME		
Funeral		5. Social Security N		6. Sex 1⊠ M 2 ☐ F	7. Ag	e (In yrs. la	as <i>t birthd</i> a Yrs.	Mon	nder 1 Year ths Days	If Under Hours	Min.	8. Date of (Month,	Birth Day, Ye	ear)	Con	place (State or intry)	0
Director		578-40-47 Usual Residence o				90					L	AUG.	8, .	1910	Washi	ington,	DC
yland now at		10a. State	10b. County			10c. City	, Town or	Location								10d. Inside Cit	y Limits
e Mar a-fsh tiffed	ctor	MARYLAND	MONTGO	MERY		CHEV	У СН	ASE								XXYes	2 No
or 28	Dire	10e. Street and Nu							. Zip Code				10g.	. Citizen of	What Cou	intry?	
ath w s 23a nust l	ral		LLAGE P	ARK DRIV		E			0815			" 1		ITED		ES ican Indian,	
ter de item	Funeral Director	11. Marital Status 1 □ Never Mari	ried 20 XMar	12. Was De Armed F	Forces?	Ever in 0.8 No 1942	o. 1	If Yes,	ecedent of Hi specify Cuba	n, Mexica	rigin? (Spi in, Puerto	Rican, etc.)	No-		ack, White		
urs af	þ	3 ☐ Widowed		If Yes. C	aive _	1946		1 □ Y€	es 餐 No	Specify	:			Speci	fy: WH]	TE	
72 hor	ted	(Sna	15. Deceden	t's Education st grade completed	v)		16a. Dec	cedent's	Usual Occupa	ation	st of work	ina	16	b. Kind of I	Business/Ir	ndustry	
ithin 7	Completed	Elementary/Seco		College		5+)	life	DO NO	OT use retired,)	St Of WORK	nig					
should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		17. Father's Name	(Eirot Middle	5+			TRI	AL_L	AWYER	19 Moth	or's Name	e (First, Mid		LAW			
d be find th	Be	LAIDLER										BOWIE	uie, iviai	uen suma	me)		
should and Me mark	ည	19a. Informant's N					19b. Ma	ailing Add	lress (Street a				mber. C	itv or Towi	n. State. Zi	ip Code)	
and 2 sealth ar		PRUDENCE			₹.			_	LLAGE					•			
item		20a. Method of Dis	position			20b. Pl	ace of Dis	position	(Name of or other place	i		Date				own, State	
Pages 1 nent of H ant: If iter		1 ☑ Burial 2 4 □ Donation		3 □Removal fror Specify)	n State			-	METERY		6/12/	2007	WAS	SHING	TON,	DC	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	uneral Service	Licensee					ne and Addres								
8 3 E F 9		W-	Lett.	Muy			-		Wiscor						, DC	20016	
			100	com lications that only one city e on	caused each li	d the death ne.	. Do not e	enter the	mode of dying	g, such a	s cardiac	or respirator	y arrest	3		Approximate Interval Betv Onset and D	ween
Physician	ĺ	Immediate Cause disease or condition resulting in death)	on					o Th	rive	С	anges:	tive He	art 1	Failur	e		
/Medical Examiner		,		MR.		a consequ Stenc											
20 to 10 to	er	Sequentially list co if any, leading to in cause. Enter Under	onditions, mmediate	b		a consequ											
executed n and ial-transit	Examiner	Cause (Disease or that initiated event	injury	A A	dult	Failur	e To '	Thriv	e								
	Exa	resulting in death)	Last	Due to	o (or as	a consequ	ence of):										
ate be hysici the bu	lical			d													
ertific ling p	by Physician/Medica	IF FEMALE;		000 15 100 0													
attenc for us	ian/	23b. Was deceder in the past 12	2 months?		birth	2 □ Fetal t time of de	death 3		oic pregnancy er (specify)						ate of deliv Ionth	-	/ear
the de	ysic	1 ☐ Yes 2 ☐ Unknowr		9□Unk		t time or de	aui .	3 🗆 Otne	i (specify)				_				
that ned by deta	Ph	Part II. Other signi	ificant conditi	ons contributing to	death b	ut not resu	Iting in the	underlyi	ing cause give	n in Part	I.	23e. D	id tobac	co use co	ntribute to	the cause of de	eath?
quires n sign	q p	Congest	ive Hea	rt Failu	re-							1	☐ Yes	2X No	3 ☐ Pro	obably 4 □U	Inknown
aw re	Completed	Aortic 8	Stenosi	9								24a. W		24b	. Were aut	opsy findings a	available
The late ha	E				-							a⊓ pi 1∏ Ye	utopsy ertorme	d? No	death?	ompletion of ca 2 □ No	luse of
stan: ertifica ctor, p	BeC	25. Was case refe examiner?	rred to medica							26. Plac	e of Deat	h (Check on					
hysic his ce Il dire	2	1 ☐ Yes 2 🔁		Hospital: 1	Inpatie	ent 2 🗆 E	ER/Outpat	ient 3⊑		4 🗆 N	ursing Ho	me 5⊠R	esidenc	e 6 🗆 O	ther (Spec	ify)	
ing P		 Manner of Dea 1 ☐ Natural 	5 Pendir	ig	e of Inju onth, Da	ıry ıy Year)	28b. Time Injur	y	28c. Injury Work			28d. Descri	be how	injury occu	ırred		
ttend death stor: /	cati	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	ce of ini	ury - At hor	me farm	M etroet fa	ictory, office	Yes 2□		28f Locatio	n (Ctro	stand Num	bor or Pu	ral Route Numi	hor
lor A after Direc	Certification:	4 Homicide	detern	nined 206. Flat	lding, et	c. (Specify)	otreet, ia	ictory, office				Town, S		ibei oi nui	rai noute Num	Jei,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical C	29a. Certifier (Check only one)	1 ☑ Certifyíi 2 ☐ Medical	ng Physician: To the Examiner: On the and ma	he best basis o	of examinat	vledge, de ion and/or	eath occur investiga	rred at the tin ation, in my o	ne, date a pinion, de	and place, eath occur	and due to red at the tir	the caus	se(s) and read and place	nanner as e, and due	stated. to the cause(s)
To the Within Го the	Me	29b. Signature and	d title of certifie		<u> </u>		\		29c. License	number			29d	. Date sign	ed (Month	, Day, Year)	
) (1	/5/12	# 14/1	50.	, 01	Λ		D-235	56			Jur	ne 7,	2007		
2	ŀ	30. Name and add	ress of person	who completed ca	use of d	leath (Item	23a) (Typ	e, Print)									
		Robert H.	Blee	MD 5530 W	lisc	onsin	Ave	. #1	400 Ch	evy (Chase	MD 2	0815	<u></u>			
Sta Registr	te	Robert H. 31. Date filed (Mor	nth Day, Year)	8 2007 32.	Registr	rar's Signat	ure	-0		-							
HMH 17 Rev 1/20			-			1800 1	S. V				-						

			For State Registrar	State of Maryland		artment of I <i>rtificate of</i>			jiene eg. No.	*7	0101
	A	T)	Decedent's Name (First, Middle, Last)					2. Date of Dea	th	Voor	3. Time of Death
	Physicia /Medic		Elizabeth A.	Manning	3			June 11		Year	10:00amM
K.	Examin	er	4a. Facility Name (If not institution, give sti				or Location of Death Bethesda			ty of Death	
	Funeral	12	5801 Nicholson Lane 5. Social Security Number 6. Sex	#135 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		tgome 9. Birthp	lace (State or Foreign
	Director		578-26-5673 ¹	M 2 🛣 F 85	Yrs.	Months Days	Hours Min.	(Month, Day 09/17/		DC Cour	ntry)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Maryli f sho ied at	ro	Maryland Montgomery	Nor	th Bet	heeda					1 X Yes 2 □ No
	r 28a	irec	10e. Street and Number	, NOI	CII DEC	10f. Zip Code		1	0g. Citizen o	What Cour	ntry?
	tth wit 23a o ust be	a D	5801 Nicholson Lar	ne #135		20852			United		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔯 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	ВІ	ace - Americ ack, White, ify: Whi	etc.
Maryland 21215-0036	ithin 72 hou ne. nan "natura Medical E	Completed by	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. l	DO NOT use retir	during most of worl	king	16b. Kind of		dustry
72	filed w Hygiel ther ti nt, th	Ö	17, Father's Name (First, Middle, Last)	Ζ	Homen	naker	18. Mother's Nam	e (First, Middle,	Own Ho		
auc	should be filed w ind Mental Hygie is marked other ti umatic event, th	To Be	Harry A. Swagart				Mildred	C. Emme	rtt	•	
ary	and M s mar		19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	ng Address (Stree	et and Number or Ru	ral Route Numbe	r, City or Tow	n, State, Zip	Code)
∑ `	and 2 lealth m 27 i		Gayle Brown / Daugh			Liberty	Tree Lane	/ Vien	na, Vi	rginia	22182
Jore	ages 1 nt of H in fite or ot		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Re	moval from State	emetery, crei	matory or other pla Cremator	ace)	.		-	, Virginia
Baltimore,	permit. Pa Departmen Important: any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service □ Cen	Nac			ress of Facility J_0				
B	permit Depar Impor any in once.		William L. B	yar	51	30 Wisco	onsin Ave.	NW Wasl	ningto	n, DC	20016
E			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one				ring, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Aspiration		nia					Onder and Death
	/Medical Examiner		1	Due to (or as a consequ	uence of):						
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	uence of):						
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last								
68760,	be exe ician a burial-	E E	resulting in death) Last	Due to (or as a consequ	uence or):						
387	ficate physi s the b	edical	d.								
Box	he death certific the attending pl thed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	⊒Ectopic pregnan ⊒ Other <i>(sp</i> ec <i>ify)</i>	су			Date of deliv Month	ery Day Year
, P.O.	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
rds	w requires been sig should be							1 🗆 Y	es 2 □ No	3□ Pro	bably 4X Unknown
Records,	و کے و	Completed						24a. Was a autop perfor	med?	prior to co death?	opsy findings available impletion of cause of
Vital	lysician; Th	Be	25. Was case referred to medical examiner?					th (Check only or	ne)		
or/	Physician: this certific	ပ္	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier	II OLI DON		ome 5 Resid			fy)
	Attending Phr r death. ector: Affer thi by the funeral	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	W	ork? ☐ Yes 2 ☐ No	200, 50001150 11	ow injury ode	arrod	
Division	allor Attend after death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, sti	reet, factory, office	9	28f. Location (S City or Tow		mber or Run	al Route Number,
	To the Hospitallor Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical C		cian: To the best of my knoer: On the basis of examina and manner stated.							
	vithi To th	ž	29b. Signature and title of certifier	1. (100)	4	29c. Licer D006	nse number	1	29d. Date sig		- '
	5		- Bremere 1	molecum	· m		140T)		June 1	۷۷ و ۲	01
			30. Name and address of person who cor Genevieve Wroblews				Rockvill	e, MD 20	850		
	Sta	ite	31. Date filed (Month, Day, Year)	32. gistrar's Signa		# .E					
	Regist	ar	JUN 1 8 201	1 Polling	16 1	neall 8					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5, perFH, g869, 7/31/07 TT 0101 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2007 Month Matthews **Physician** Kathryn June 13, 1:23 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda "Inder 1 Year | If Under 24 Hrs. | Min. Springhouse at Westwood Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours **579** 578-48-8131 1 □ M 2√2 F 83 1924 Mexico June 12, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or Items 23a or 28a-f shovediral Examiner must be notified at 1 X Yes 2 □ No Maryland Montgomery Bethesda Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 5101 Ridgefield Road 20816 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Pressly Mary Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David P. Matthews / Son 663 South 400 West Salt Lake City, UT 84101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Removal from State 06/19/2007 Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Leukemia **Physician** disease or condition resulting in death) Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 1 Yes 2 1 No 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 🗋 Unknown by 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No 1□ Yes or Attending Physician: Assisted funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 X Natural s after death. I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours af To the Funeral D Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

10

To the

31. Date filed (Month Day 18 2007

29b. Signature and title of certifier

Lila T. McConnell MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D39456

29d. Date signed (Month, Day, Year)

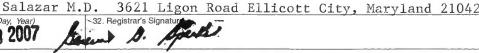
June 14, 2007

State Registrar

Physician /Medical Examiner Funeral	Karnerine Cra	_ast)		-					
Examiner Funeral		ne Miller				2. Date of Dea Month June	ath Day 14	Year 2007	3. Time of Death 7:15 and
Funeral				4b. City, Town, or	Location of Death			ty of Death	
3	Montgomery Gener	al Hospital		01n	еу		Mo	ntgomer	У
	233-44-5037	Sex 7. Age 1 M 2 ☑ F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day March 1.	r, Year)	Count	ace <i>(State or Foreign</i> try) Virginia
*	Usual Residence of Decedent 10a, State 10b. County		10c. City, Town o	or Location				10	Od. Inside City Limits
than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at ompleted by Funeral Director	Maryland Montgo	mery		Silver Sp	ring				1 □ Yes 2 ☑ No
or 28a-f s be notified Director	10e. Street and Number			10f. Zìp Code			10g. Citizen of	What Count	try?
s 23a nust k					20905			U.S.A.	
tial Hygiene." d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at event, Be Completed by Funeral Director		If Yes, Give	ver in U.S.	13. Was Decedent of H. If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)	14. Ra Bl: Spec	ace - America ack, White, e	
natural' lical Ex	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's (Specify only highest)		16a. D	ecedent's Usual Occup	ation	king	16b. Kind of I	Oau	
ygiene. ner than "natur: nt, the Medical E	Elementary/Secondary (0-12)	College (1-4or 5+ 2	·) 'li	Give kind of work done of the DO NOT use retired Dental Ass:	•	King		Dentist	
ad other event, the Be Co					18. Mother's Nam	ne (First, Middle,			
Mental H arked ott atic ever To Be					Garnet	E. Taylor			
is marked raumatic ev	19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (Street a				n, State, Zip	Code)
alth a 127 is er tra	Patrick Miller -	Son	174	16 Astoria La	ne, Silver	Spring, M	aryland	20905	
of He	20a. Method of Disposition	Domesial from State	20b. Place of D cemetery,	isposition (Name of crematory or other place	e)	Date	20c. Location	- City or Tov	wn, State
ant: If	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			coln Crematory	T1	2, 2007	Brentwo	od. Mar	vland
Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. TO B	21. Signature of Funeral Service Lic	ensee		22. Name and Addres Hines-Rinald 11800 New Har	i Funeral F	Home, Inc.	er Sprin	o Mary	land 20904
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be detached for use as the burial-transit and page 3 should be a should b	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	consequence of)	:					Approximate Interval Between Onset and Death
d by the attending phetached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	☐ Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)				ate of deliver	ry Day Year
igned by be deta	Part II. Other significant conditions								e cause of death?
hould	PERFORATED CO	EUM GIG	101 191	M M CEH W	YEHIA	'''	′es 2 No	3 Proba	ably 4 Onknow
cate has been s page 2 should	PHEUMONIA	उट्टी।१						prior to con	osy findings available apletion of cause of 2□No ~14
ector Be		Hospital:		l out	26. Place of Dea	th (Check only o	ne)		
this ald dir	07.11	28a. Date of Injury	t 2 ER/Outpa		4 LI Nursing H	ome 5 Resid)
After fune tion	1 Natural 5 Pending	(Month, Day		iry Work	/aι (? Yes 2∐No	28d. Describe h	ow injury occi	ırrea	
al Director: After led in by the funer. Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 200 Place of injur	ry - At home, farm (Specify)	, street, factory, office	103 2 10	28f. Location (S City or Tow		nber or Rural	Route Number,
o the Funeral ompletely filled Medical C		Physician: To the best of aminer: On the basis of and manner stat	examination and/o	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and n	nanner as sta e, and due to	ated. the cause(s)
To th	29b. Signature and title of certifier			29c. License	number	- 2	29d. Date sign	ed (Month, E	Day, Year)
٥	by filmie M				8542	Ag)ديو	14, 20	.37
	30. Name and address of person wh	o completed cause of de コピィーカックで	ath (Item 23a) (Ty これい VI C	rpe, Print) 、10605 ここん	CORD ST	REET #	500	KEHJ	INGTUN!

Andres 31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 **Physician** Olina 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde Medical Cent nnapolis 4nne If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0 6 108 1200 7 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Country) Maryland Days 3.5 1 ☐ M 2 🥦 F Months NONE Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Cuban-Amer. 2□ No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be inaton Meier Jusana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1828 A St. SE. Washington, DC 20003 19a. Informant's Name/Relationsl 20b. Place of Disposition (Name of cemetery, crematory or other place)

CREMATION CENTRE 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 18-07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses murphy FH 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Perinatal deocession /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 0 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 💢 No autopsy performe this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To **↑** Inpatient completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rindfleisch Suzanne 2001 Medical

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

JUN 1 8 2007

20

32. Registrar's Sig

			For State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Depar	artment of Health and I Stificate of Death		iene eg. No.	0101.0
	Physicia	an *	1. Decedent's Name (First, Middle, Last)		2. Date of Death JUNE 7	h Calain I	3. Time of Death
	/Medic	al	ISRAEL NA'IM MELTON	4h City Town or Location of Doct		Day Year 2007	1:50PM
)	Examin	er	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER	4b. City, Town, or Location of Death ANNAPOLIS		ANNE ARUN	DEL
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) NONE 1 M 2 □ F Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 46	8. Date of Birth (Month, Day, JUNE 7	Year) 9. Birthp Cour 2007 MARY	elace (State or Foreign htry) LAND
	and www.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Mary a-f sho fied a	tor	MD PRINCE GEORGE'S CAPITO	L HEIGHTS			1∭Yes 2□No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 1311 KAREN BLVE # 302	10f. Zip Code 20743	10	0g. Citizen of What Cour	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 M Never Married 2 Married 1 TYes 2 内 No	Nas Decedent of Hispanic Origin? (S f Yes, spedfy Cuban, Mexican, Puerl I □ Yes 2፟፟፟፝ No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ho ene. than "natur he Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NO	lent's Usual Occupation kind of work done during most of wor OO NOT use retired) N.F.	kíng 1	16b. Kind of Business/In	dustry
d 2	i filed I Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, N		
ylan	ould be Menta arked atic ev	To B	LAFAYETTE DUVAL MELTON		E SHERRAI		
, Mar	and 2 sho salth and 1 27 is ma er trauma			g Address (Street and Number or Ru KAREN BLVD # 302			
Baltimore, Maryland	Pages 1 ment of He ant: If iten ury or oth	3	115/Burial 21 (Cremation 31 (Bernoval from State 1	natory or other place) ;		20c. Location - City or To ANDOVER, MAR	
Balt	permit. Depart Import any inj	2 5		Name and Address of Facility 474 LANDOVER ROAL		KINS FUNERA R,MARYLAND	L HOME 20785
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) EXTREME PREMATURI Due to (or as a consequence of):	TY			
	Examiner						
70	D its	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury				
Ö,	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C				
68760,	cate be physici the bu	edical	d				
Вох	death certifi e attending d for use as	Physician/Me		Ectopic pregnancy		23d. Date of delive	ery Day Year
P.0	law requires that the de as been signed by the a 2 should be detached f	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to the	ne cause of death?
rds	w requires been sign should be	ed by			1	es 2∱∑ No 3 ☐ Prot	pably 4 □Unknown
Il Records,	The ate ha	Completed			24a. Was ar autops perforn 1∐ Yes 2	y prior to co ned? death?	psy findings available mpletion of cause of
Vita	Physician: Tr r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Other	ath (Check only one	e)	
o	Phys r this ral dii	5	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing F	lome 5 ☐ Reside	ence 6 Other (Special	'y)
ion	Attending r death. ector: After by the fune	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division or Vital	i Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or Rura n, State)	al Route Number,
	ne Hospital n 24 hours a he Funeral pletely filled	Medical (29a. Certifier (Check only one) 11→ Certifying Physician: To the best of my knowledge, deatt 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month,	Day, Year)
1			Chasey Rised, no	06057324		2214110	07
1	-		30. Name and address of person who completed cause of death (Item 23a) (Type,	^{Print)} N. Hanson Ct. Su:	ite 304 B	owie. MD 20	716
	Sta Registr		31. Date filed (Month, Day, Year) 111N T R 2007	,			

			1 - For State Registrar	State of Ma	rylan		artmer rtificat			and M	lental h	Reg. N	6- 6- 6	7 21	249
*	Physici	an	Decedent's Name (First, Middle, Last) Stewell	A.	Mata	L				June		Yea		
	/Media		4a. Facility Name (If not institution, give		A.	MCII	tyre	T	Location o	- Denth	June		2007 c. County of De	7:25	5 A ^M
+3	Examir	ier	Prince George's		Cent	er	,	heve		Death				George's	
6.	Funeral	** ~	5. Social Security Number 6. Se			last birthday)	If Unde		If Under	24 Hrs.	8. Date of			Birthplace (State Country)	
	Funeral Director		217-73-7378	X M 2□F	66	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, April	27,	1941 J	Country) amaica,	W.I.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside (City Limits
	Maryl	to	Maryland Prince G	eorge's				Uppe	er Mai	rlbo	ro			1 ½ Ye	s 2 No
	or 28c)irec	10e. Street and Number				10f. Zip					10g. C	itizen of What	Country?	
	ath w	rai	109 Herrington D)774					ca, W.I.	
36	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Iteme 23a or 28e-f ehow event. I'm Medical Eracid at most be profited at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2√2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			Was Dece f Yes, spe 1 ☐ Yes		spanic Origin, Mexican Specify:	gin? (Span, Puerto	ecify Yes or Rican, etc.)	No-	Black, W		
8	tural	ed b	15. Decedent's Edu	Year or Dates:	-	16a. Deced	dent's Usu	al Occupa	ition			16h	L Kind of Busine	3lack	
21215-0036	nin 72	plet	(Specify only highest grad			(Give	kind of wo	rk done a	lurina most	t of work.	ing	100.	Ciria or Dasine	33/maastry	
2	giene giene	E O	12th	College (1-401 5+	,		D:	river	2				Priva	ate	
Maryland	should be filed and Mental Hygies marked other umatic event, It	To Be C	17. Father's Name (First, Middle, Last) Joseph McIntyre	9							e (First, Mid h Arno		n Sumame)		
			19a. Informant's Name/Relationship (T) Ruth McIntyre	(Wife)									or Town, State	9, Zip Code) ID 20774	
ore,	ss 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. P	lace of Dispo emetery, cres	sition (Nai	me of other place	9)	[Date	20c. l	ocation - City	or Town, State	
Ĕ	Pages ment of ant: If its ury or o		1 🔀 urial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			urrect	ion (Cemet	ery	6/29	/2007	Cl	inton,	Marylan	d
Baltimore,	permit. Departi		21. Signature of Funeral Service Licens	timere									ral Ser MD 2070	vices, 06	P.A.
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ilications that caused it ne cause on each line Pulmonar Due to (or as a Peripher Due to (or as a Due to (or as a	consequal 1	mbolus uence of): muscul					or respirator	y arrest,		Approxima Interval Be Onset and	etween
68760,	death certificate be executed e attending physicien and id for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	uence of):									
. Box	at the death certific by the attending parached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal	death 3[]Ectopic p] Other (sp					_	23d. Date of o	delivery Day	Year
	or Attending Physicien: The law requires that the that death. Diffector: After this certificate has been signed by the bliector: After this certificate has been signed by the bliector; page 2 should be detached by the funeral director, page 2 should be detached.	ρ	Part II. Other significant conditions co Hypertension	ntributing to death but	not resu	ulting in the u	nderlying o	ause give	n in Part I.			id tobacco		to the cause of	
O လ	aw rec is beel 2 shou	Completed	Type I Diabete	es Mellitus	5						24a. W		24b. Were	autopsy findings	s available
ř	rsicien: The law s certificate has b lirector, page 2 s	Com									pe 1 ☐ Ye	utopsy enformed? s 2 N	o 1 🗆 Y		cause or
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?							of Death	(Check on				
5	Physi this c al dire	To	145 TOS 2 140	dospital: 1 ☐ fnpatient		ER/Outpatien			4 140				6 □Other (S	pecify)	
0	ding I h. After funer	tion	27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of fnjury (Month, Day 1	rear)	28b. Time of fnjury	м 2	8c. Injury Work	at ? ′es 2 ⊡≀		28d. Descri	be how inj	ary occurred		
Division of Vital Records,	I or Atten after deat Director: I in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injun building, etc.	/ - At ho (Specify	me, farm, str						n (Street a Town, Sta		Rural Route Nui	mber,
	Hospitel or Atten 24 hours after deatl Funerel Director: etely filled in by the	Medicai C	29a. Certifier (Check only one) 1 Cartifying Phy 2 Medical Exemi	sician: To the best of ner: On the basis of e and manner state	xaminat	wledge, death ion and/or inv	occurred estigation	at the tim , in my op	e, date and inion, deat	d place, th occurr	and due to t ed at the tin	he cause(ne, date ar	s) and manner nd place, and d	as stated. lue to the cause	(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				290	c. License	number			29d. D	ate signed (Mo	onth, Day, Year)	
			•	/1.		>		DE	3594	7		61	14/0-	7	
2	(4)		30. Name and address of person who con Norman McKoy, N								2, Mit			MD 207	21
	Sta Registr		31. Date filed (Month, Day Year)	32. Registrar							,		······································		

07-04544	07-04544
----------	----------

Elizabeth Nwachukwu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

 . , , , , , , , , , , , , , , , , , , ,			
State of Maryland	Department of He	ealth and Mental Hygi	ene

_	Physici		1- For State Registrar 1. Decedent's Name (First, Middle,Last)		Certificate	of Death	2.	Reg.		3. Time of Death
Med	dical Exam		Elizabeth Nwach	aku Eliza	beth Nwachi	ikwu	J	Month Da June 14, 200	ay Year)7	0010 hrs
			4a. Facility Name (if not institution, give s 1902 Viersmill Rd.			4b. City, Town, or L Rockville	ocation of Death		4c. County of Death Montgomery	1
	Funeral Director			7. Age (I	n yrs. last birthday) If Under 1 Year Months Days	Hours Min	3. Date of Birth(N	MM/DD/YYYY) 9. Bir Foreig Co	
	any		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
^	nd show s	_	Unk	Unk.					Unknown	1 Yes 2 X No
0	Maryla 28a-f	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
-	h the l 3a or otifie	l Dir			Unknow			nk.		Unk.
0	ath wit tems 2 st be r	Funeral	11. Marital Status Unknown Never Married 2 Married	12. Was Decedent Ev Armed Forces?		Was Decedent of Hisp If Yes, specify Cuban,			14. Race - Amer White, etc.	ican Indian, Black,
	fter de: '', or i er mu	/ Fu		1 Yes 2 Yes, Give Year Unkn		Yes 2 X No	specify:		Specify: B	lack
	ours al atural xamin	d by	15. Decedent's Education (Specify only	highest grade comple	eted) 16a. Dece	dent's Usual Occupation			6b. Kind of Business/	Industry
	36 n 72 h nan "n ical E	olete	Elementary/Secondary (0-12) Unknown	College (1-4 or 5+)	dulli	g most or working me.				
	-003 d withing spiene.	Completed	17. Father's Name (First, Middle, Last)			1	8.Mother's Name (Fi	known irst, Middle, Mai	den Surname)	Unknown
	215 be files ntal Hy rked o ent, th	Be C	Unknown				Unknown			
	21 should nd Me is ma atic ev	မ	19a. Informant's Name/Relationship (Typ		3.	iling Address (Street				e, Zip Code)
	, MI and 2 s ealth a em 27 rraum		Blessing Anyah 20a. Method of Disposition	/ Niece		Underhill position (Name of cen			CA 94610 Oc. Location - City or	Town, State
•	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	300	1 Burial 2 X Cremation 3	Removal from State	crematory of	r other place)	.		•	·
	ltin nit. Pe artmer oortan ury or	dr	4 Donation 5 Other Specify: 21. Signature of Funeral Service License	e	FC. L1n	coln Crema 2. Name and Address	of Facility Cimp	0/0/ .	brentwood	, Maryland
	, 		US. (1)		(4)	1040 Rockv	ille Pike	. Rockv	ille, Mary	yland 20852
	Physician /Medical		23a. P. L. Enter the dis se, or complication ail re. List only one cause on each		e death. Do not en	er the mode of dying,	such as cardiac or re	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and
	Examiner			Ketoacidosis le to (or as a consegu		n, ather scl	rotic cardi	ovascular	diana	Death
			Sequentially list conditions, b							
		iner	if any, leading to immediate Decause. Enter Underlying Cause	ie to (or as a consequ	isnos of):					
	ed sit	Examiner		ie to (or as a consequ	ence of):		<u>-</u>			
	760, icate be executed physician and the burial - transit	edical E	d. X UNPENDED	AMENDED		= 1 = 1 = m				
	'60, zate be o ohysiciz ne buriz	Medi	IF FEMALE:	#23a,27,#1, 23c. If yes, outcome	perME, g869	, 7/13/07 TT			23d. Date of deliver	\
	certific reding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death 3	Ectopic pregnancy	у	Month	Day Year
	Box 687 Re death certific the attending p	Physician/	1 Yes 2 No 9 V Unknown	9 Unknown	ne or death 5	Other (Specify)				
			Part II. Other significant conditions	ontributing to death b	ut not resulting in t	he underlying cause g	iven in Part I.		acco use contribute to	
	Records, P.C. The law requires that cate has been signed by	ed by								bably 4 Unknown
	ord aw req as bee 2 shoul	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	Rec The I ficate I	Som						1 ✔ Yes 2	No 1 ✓ Y	es 2 No
	ital sician: s certi irector	Be	25. Was case referred to medical examiner?	spital: 1 Inpatient	2 ER/Outpat		of Death (Check online) Other Nursing F		esidence 6 🗸 Othe	or Scana
	n of Vital I ling Physician: After this certifi funeral director,	۲. ۲	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year			- Tolonig t		w injury occurred	doctio
		atio	1 X Natural 5 Pending 2 Accident Investigation		' 	1Y	es 2 No			
3	Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	Certification:	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm,	street, factory, office be	uilding, etc. 28	or Town, Stat		ural Route Number, City
0	Division Hospital or Attend 24 hours after death. Funeral Director:		4 Homicide determined	(Specify)					-) and manner on ato	tod.
	Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 ✓ Medical Examiner: 0			ccurred at the time, da tigation, in my opinion,				
	T wi	Me	29b. Signature and title of certifier	ng manner stateg.	-	29c. License	number	2	29d. Date signed (Mo	onth, Day, Year)
			and of	seen 1	NO	O.C.N	И.Е. 		June 14, 2007	
			30. Name and address of person who co Tasha Greenberg MD. As	mpleted cause of dea sistant Medical		11 Penn Street, I	Baltimore, MD 2	21201		
	<u>_</u>	tate	31. Date filed (Mg1/1)(Pay, 2Par) 7 201			barte	,	•		
	Regis	trar	JUIT N 1 200	- KISTER	150 /6		·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 4:43Р м Carol J. Orwant 11 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 092-30-9457 71 Jan. 1, 1936 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show at 1 Tyes 2X No Examiner must be notified Director Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1887 Milboro Drive × 23a 20854 United States Funeral 14. Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☑ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ Caucasian 3 Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Scientist Information Technology 7 is marked other traumatic event. tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t and 2 should be fill Health and Mental H Im 27 is marked otl Be Marcella Janet Davis Max Cohen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 1887 Milboro Drive, Potomac, MD 20854 Jack Orwant/Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/19/2007 Ft. Lincoln Crematory Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen, e 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 0 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. signed by the a 1 ☐ Yes 2 🖾 No detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ģ 1 Tyes 2 TNo 3 TProbably 4 to Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director After this completely filled in by the funeral dir this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 🖾 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 6/12/07 D0064615 30. Nume and address of person who completed cause of death (Item 2 la) (Type, Print) Geneviere Wroblewski, M.D.- 1335 Piccard Drive, Rockville, MD 20850 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

Day, Year)

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVI	aryland / Depa <i>Cer</i>	rtificate of L		•	giene Reg. No.		3.1 2 17.0
	Physici	an »	1. Decedent's Name (First, Middle, Last) RUTH I. OLANI	<u> </u>			2. Date of De	ath Day 13	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	JUNE		2007 ity of Death	14:40P M
			SHADY GROVE ADVENTIST HOS		ROCKV			ı	10NTGO1	MERY
14	Funeral Director		5. Social Security Number 212-05-3047 G. Sex 1	ge (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Sept. 2	y, Year)		ace (State or Foreign try) aryland
	e Maryland 3a-f show tified at	ctor	10a. State 10b. County Md. Montgomery	10c. City, Town or Loc Gaithe	ersburg				10	0d. Inside City Limits 1 Yes 2 □ No
	th with th 23a or 26 ast be no	al Director	10e. Street and Number 333 Russell Avenue, #119	•	10f. Zip Code	20877		10g. Citizen d Un i	f What Count ted St	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces It Yes, Give Year or Dates:	? If	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ※ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. R B	ace - America lack, White, e	
Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give I	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of word)	king		Business/Ind	lustry
2	led wi dygien her th nt, th	Co	12 0	HOM	emaker	19 Mothor's Nor	o (First Middle			
land	0 7 5	To Be	Clagett Higgins			18. Mother's Nam Mae	Wachte:		ame)	
	and 2 should ealth and Men n 27 is marke her traumatic		19a. Informant's Name/Relationship (Type. Print) Charles D. Oland, Jr./Neph	I	g Address <i>(Street a</i> 749 Jacob					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic enonce.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem St. John			Date 18/07		ey, Mo	.,
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee Muriel & Bar	her 22		ss of Facility Barber Sox 5038,			Md. 2	20882
68/60,	Physician / Medical Examiner as the prival-transit as the prival-t	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jissas of Figure 1 that initiated events cause.	a the death. Do not enterine. Pumonia a consequence of): a consequence of): a a consequence of):	er the mode of dyin	g, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death 5 Days
O. Box 68	The law requires that the death certificate has been signed by the attending playing 2 should be detached for use as to	Physician/Med		2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				Date of deliver	ry Day Year
1	w requires that s been signed by should be deta	þ	Part II. Other significant conditions contributing to death t	out not resulting in the un	nderlying cause give	en in Part I.				e cause of death?
Vital Records,	hysician: The law rec his certificate has beel I director, page 2 shou	Completed					24a. Was autop perfo		o. Were autop prior to con death? 1 □ Yes	osy findings available npletion of cause of
II a		Be C	25. Was case referred to medical examiner?			26. Place of Dea			T Tes	2 140
n or v	ding Physic h. After this of funeral dire	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpati 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Date of Inj	ury 28b. Time of	28c. Injury Work	y at </td <td>ome 5 Resid</td> <td></td> <td></td> <td>()</td>	ome 5 Resid			()
DIVISION	e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifical etely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm, stre tc. (Specify)		Yes 2 □ No	28f. Location (S City or Tox		mber or Rural	l Route Number,
-	24 hours a Funeral stely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the dasis and manner st	of examination and/or inv						
	To the Hosp within 24 ho To the Fund completely f	Me	29b. Signature and ple of certifier		29c. License	e number		29d. Date sign	ned (Month, L	Day, Year)
)	10		► Off De St	m		64415		Jur	ne 14,	2007
	•		30. Name and address of person who completed cause of Nimesh Shah, M.D. 9901	death (Item 23a) (Type, F Medical Ce		e, Rockv	ille, Mo	d. 208	350	
	Sta Registr		•	rar's Signature	mark s					

The state of the s	Physici /Medic Examir	cal	1 - 1.
	Funeral Director		5.
			Us
	land ow		Us 10
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10
036	ours after deat ral", or items 2 Examiner mu	by Funera	11.
5-0	72 hc 'natu dical	etec	
121	within ene. than '	mpl	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: If item 27 is marked other than iny Injury or other traumatic event, the Monce.	To Be Co	17
lar	2 sho and I is ma	ľ	19
<u>ک</u>	l and lealth im 27 ther tr		19 K
mor	Pages ment of Hant of Hant of Hant of Hant of Hant of Hant or old	,	20.
Balt	permit. Departi Imports any inj		21
			23
), ,	Physician /Medical Examiner		Im di: re
r	cuted id	aminer	Se if a ca Ca tha

After

Box 68760.

P.O.

Records,

Division or Vital

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day $a^{\ M}$ 2007 8:25 Michael Patrick O'Connor June 16, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth
(Month, Day, Year) Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**₹**] M 2 □ F Months Days Hours 57 New York 082-38-6960 sual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring laryland Montgomery e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8813 Woodland Drive 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University Religious Elementary/Secondary (0-12) College (1-4or 5+) 5+ Ordinary Professor/Dept. Chair Education Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John David O'Connor, Sr. Anna Maria Crosta 9a. Informant's Name/Relationship *(Typ*e. *Print)* (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathleen Anne O'Connor-Mullen 15 Metzger Drive, Orchard Park, NY 14127 20b. Place of Disposition (Name of cemetery, crematory or other place) Date a. Method of Disposition 20c. Location - City or Town, State June 1 ☐ Burial 2 【** Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Dother (Specify) 2007 Alexandria, Virginia Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 3a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Hepatocellular Carcinoma sease or condition sulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) EX Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ဥ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: the Hospital or Attending nin 24 hours after death. (Month, Day Year) Injury 1 X Natural 5 Pending investigation M 1 ∏Yes 2 ∏No al Director: / 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital
within 24 hours afte
To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40064588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Ashish Tolia, M.D. 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State JUN 18 2007

Registrar

	Phy //\ Ex	ysid Ned	cia lic
	Ex	am	in
DIVISION OF VICAL DECORAS, P.O. BOX 00/00,	spital or Attending Physician: The law requires that the death certificate be executed	nours after deaut. Ineral Director: After this certificate has been signed by the attending physician and	y filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1	State Registrar				Cer	tificate	of E	Death			Reg. No.	40	UI	. eq	20.
表演		1. Decedent's Name (F	First, Middle, La	st)								Date of Death Month Day Year 3. Time of E				
Physicia /Medic		Mildred	P	ickus							June	16		2007	10:	:30 ам
Examine		4a. Facility Name (If no	t institution, giv	e street and nu	mber)		4b. City, To	wn, or	Location of	f Death		4c. County of Dea				-
	â.	Manor Care	e-Potomac						Potoma			Montgomery				
Funeral		5. Social Security Num		Sex I□M 2⊠F	7. Age (In yrs		If Under 1 Months E	Year Days	If Under :	24 Hrs. Min.	Date of Bir (Month, Da	th a <i>y, Year)</i>		9. Birthp	lace (State	or Foreign
Director		115-30-897	0	ILIMI ZMIF	9	3 Yrs.					November	21,1	.913	Newar	k, New	Jersey
pu ,	-	Usual Residence of De	ecedent Ob. County		10c C	ity, Town or Lo	cation	_		_				1	0d. Inside (Pity Limite
aryla shov d at	_	10a. State	Jb. County		100.0	ity, TOWITO: LO								'		S 2√∑ No
e Ma-f	응	Maryland	Montgome	ry			Chevy (е			10g. Citizen of What Country?				
or 2	Director	10e. Street and Number	er				10f. Zip Co	ode				10g. Citi	izen of V	Vhat Cour	itry?	
23a ust t	<u>e</u>	4701 Willa:	rd Avenue						20815				44.5	U.S.A		
tems	Funeral	11. Marital Status		Armed F		J.S. 13. \	Nas Deceder f Yes, specify	nt of His y Cubai	spanic On n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	an Indian, etc.	
a filed within 72 hours after death with the Maryland a filed within 72 hours after death with the Maryland other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	by F	1 Never Married		If Yes, G			1 □ Yes 2 2	No.	Specify:				Specify	·: 54T	hite	
hour ural	8 9	3 🖾 Widowed 4		Year or [16a Decer	dent's Usual (Occupa	ation			16h K	ind of Ru	siness/In		
nat 'nat	Completed	(Specify	 Decedent's E only highest gra 	ade co <i>mpleted)</i>		(Give	kind of work	done d	luring mosi)	t of worki	ing	100. K	ind of Bu	15111622/111	uusuy	
withir than than the M	립	Elementary/Seconda 12	ary (0-12)	College (1-4or 5+)		Homema							Own H	OMA	
lied hygic	ပ္ပ	17. Father's Name (Fir	rst Middle Last)			Homema		18. Mothe	r's Name	e (First, Middle	. Maiden	Surnam		Ollic	
ntal led o	Be	,		,												
d Me nark natic	ဍ	Sam Shu		Time Print)		10h Mailir	a Addrose /6	Stroot a			ia Bornst a <i>l Route Numb</i>		or Town	State Zir	(Codo)	
d 2 sl h an 7 Is r traur																
Healt Healt Sm 2	-	Natalie P 20a. Method of Disposi		Daughte	r20b.						Chevy Ch				0815 own, State	
7 g = 1 ge		1 ☑ Burial 2 □ C	Cremation 3		State	Place of Dispo cemetery, crer			1							
than thank and the same of the	-	4 □ Donation 5			Ju	idean Mem					7/2007	Olne	y, Ma	arylan	d	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inspermit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Insperment of Health and Mortel Hydren. Insperment it is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funer	ral Service Lice	nsee	1011	Hi	Rame and Rina	aldi	Funer	al Ho	ome, Inc.			14	1 1 0	2001
0.012 60 01		Una	naa	Tue	lewco						nue, Silv		ring,	, Mary	Approxima	
		23a. Part1. Enter the shock, or heart fa	allure. List offly	one cause on	each line.	n. Do not ent	er the mode (or ayıng	g, such as	cardiac	or respiratory a	arrest,			Interval Be	etween
Physician		Immediate Cause (Fin disease or condition	al	_aDer	mentia											
/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):										
4	_	Sequentially list condit	tions,		pertensio											
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Caronary Artery Disease														
ecute and tran	кап	that initiated events resulting in death) Las	_		ronary Ar (or as a conse		ery Disease									
be ey cian ourial	一					,										
certificate be executed ding physician and ise as the burial-transit	Medical		•	dCII	ronic Rer	iai insur	rrcrenc	у								
ding se as		IF FEMALE:		23c If yes or	itcome pf pregr	nancy							004 Det	to of dollar		
attendi for use	ian	23b. Was decedent pr in the past 12 mg	onths?	1□Live	birth 2 ☐ Fe nant at time of	tal death 3 □	Ectopic preg							te of deliventh	Day	Year
the de	Physician	1 ☐ Yes 2 ☒ N 9 ☐ Unknown	lo	9□Unki		ueam 5L	_Other (spec	Juy)								
		Part II. Other significa	ant conditions	contributing to	death but not re	sulting in the u	nderlying cau	ıse give	en in Part I		23e, Did	tobacco	use cont	ribute to t	he cause of	death?
w requires to been signer should be	b										10	Yes 2	□No	3 Prol	oably 4 ⊠]Unknown
w requ	Completed										0.4- 104		T 0.01. 1	141		
has h	dr.										24a. Was		24b.	were auto prior to co d <u>ea</u> th?	psy finding: mpletion of	s available cause of
	3			_							1□ Yes)	1 🗆 Yes	2□ No	
Physician: T this certificate al director, pa	Be	25. Was case referred examiner?	I to medical	Hospital:				TOtho		of Deat	h (Check only	one)				
ohysi this o	ို	1 ☐ Yes 2 ☑ No)	1_	Inpatient 2[_	4 XI NL		me 5 Res				fy)	
ing 'Affer uner	.: 0	27. Manner of Death 1 Natural	5 Pending	,	nth, Day Year)	28b. Time o Injury		c. Injury Work			28d. Describe	now inju	ry occuri	rea		
teath feath for:	cati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b		a of initial At I	homo form str	M .		Yes 2□		Opt Leasting	/C+ +	t & transla		of Paulo No.	
or Attending Physician: ifter death. Director: After this certific in by the funeral director,	Certification:	4 ☐ Homicide	determined	ZOC. FIAU	e of injury - At I ding, etc. <i>(Sp</i> ec	nome, iaim, su aify)	eet, factory, t	onice			28f. Location (City or To	wn, State	e)	er or n ur	ai moute ivu	mber,
pital urs a eral l		20a Cortifica 1	☑ CertifyIng P	huoloians To th	a host of mu kr	outodas daat	h accurred at	t the tim	no data ar	nd place	and due to the	2.001100/0) and ms	annor ac a	etated	
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the fi	Medical		Medical Exa	miner: On the												e(s)
o the orple omple	Mec	29b. Signature and titl	e of certifier	and ma)		29c. l	License	number		-	29d. Da	ite signe	d (Month.	Day, Year)	
F \$ F 8			120	Vol	va 1	M.D								6, 200		
1	-	70 No.		name to to t		00-1 /T		D202	. / 4			JU	THE T	, 200		
		30. Name and address						22777	and of	1817						
Sta	0	Kirti Voh	Day, Year)	32.	Boistrar's Sign	nature	esua, M	aryl	and ZC	/OT/						
Sta: Registra	ar	31. Date filed (Month	JN 18	2007	Com	M. A	bester									
					- Contraction	20 M	participation									

			for State Registrar	State of Ma	-	Certificate of			eg. No. 🛴 🕠	57	2125		
Ţ	Physici		1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month	th Day	Year	3. Time of Death		
	/Medic		Henry Anthony	Perfetto				June 1	4, 2007		6:15 ^p ^M		
7	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County				
	Francis		Bethesda Health 5. Social Security Number 6. S		(In yrs. last birth	Betheso day) If Under 1 Year		8. Date of Birth	Monto	9. Birth	place (State or Foreign		
	Funeral Director			X IM 2□F	80 Y	Months Days	Hours Min.	(Month, Day, Feb. 24,	Year)	COL	nnsylvania		
	/land low at		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
	a-f sh ified	ctor	Maryland Montgo	mery	01	ney					1 ☐ Yes 2 🔀 No		
	with the 3a or 28 it be not	Funeral Director	10e. Street and Number 3717 King Willi			10f. Zip Code 20i	832	1	0	itizen of What Country? USA			
	death ms 2 r mus	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spe	ecify Yes or No-			ican Indian,		
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	1 Never Married 25M Arried 3 Widowed 4 Divorced	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 ☐ Yes 2 ☑ No		nican, etc.)		k, White ::Whi			
ל ק	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	Decedent's Usual Occup	ation during most of work	ina	16b. Kind of Bu	siness/l	ndustry		
7	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+) '	Give kind of work done life. DO NOT use retired		,,,g					
2	lled w Hygiel her th	S	17. Father's Name (First, Middle, Last)	4		Electrical	Engineer 18. Mother's Name	/First Middle I			vernment		
anc	d be fi	Be	Anthony Michael				Matilda C	, .	viaiueri Surriairi	c)			
Maryland	mit. Pages 1 and 2 should b partment of Health and Ments portant: If Item 27 Is marked y injury or other traumatic e	욘	19a. Informant's Name/Relationship (19b. ľ	Vailing Address (Street			r, City or Town,	State, Z	ip Code)		
Ĕ	and 2 salth a 1 27 is		Martha E. Perfett	o/Wife	371	.7 King Wil	liam Driv	e, Olney	, Maryl	Land	20832		
Baltimore,	of He filter		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐	Removal from State	20b. Place of D	Disposition (Name of crematory or other place	ce) Ju	ne 19,	20c. Location -	City or 7	Town, State		
Ĕ	Pag Iment Iant: I		4 □ Donation 5 □ Other (Specif	y)	Gate c	f Heaven C					ng, Maryland		
Za E	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	isee		Francis Addy							
ű.	E - 2 6 0	S 1	23a Part1 Enter he disease or com	plications that caused t	e death Do no	500 Unive	rsity Blv	d, W., S	Silver S	Spri	ng, MD 20901 Approximate Interval Between		
	-	51 7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Metastatic Malignant Melanoma										
	Physician /Medical		disease or condition resulting in death)	-	Months_								
	Examiner				consequence of						Months		
	NEWS PROPERTY.	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		conse uence of					- 14	MODILITS		
	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		Cerebrovascular Accident						Months		
60,	oe execian a	Ã	resulting in death) Last	Due to (or as a consequence of):									
09/89	cate physicate the the the the the the the the the t	ledical		_d						-			
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p				211	23d. Dat	te of deli	verv		
C. Box	The law requires that the death cer tte has been signed by the attendin bage 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at t 9□Unknown		3 □Ectopic pregnanc 5 □ Other (specify) _	у		Mo		Day Year		
1	that t ed by detac		Part II. Other significant conditions of	ontributing to death but	not resulting in t	he underlying cause giv	en in Part I.	23e. Did tol	bacco use contr	ribute to	the cause of death?		
S	quires n sign lid be	d by	Diabetes, Sacral	Decubitus	. Hypert	ension		1 □ Y	es 2 □ No	3 ☐ Pro	obably 4x Unknown		
Vital Records,	aw rec s bee 2 shou	Completed						24a. Was a		Were au	topsy findings available		
ř	sician: The law certificate has l irector, page 2 s	ШО						autops perfori 1⊟ Yes	m <u>ed?</u>	death?	ompletion of cause of 2 ☐ No		
<u>a</u>	ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat						
o 	Physician: r this certifica ral director, p	P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien		oatient 3 DOA Oth	4 🔀 Nursing Ho	me 5 Reside			cify)		
	ing P	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tii Year) Inj	ury Wo		28d. Describe ho	ow injury occurr	ed			
DIVISION	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		v - At home, fam	M 1 □ n, street, factory, office	Yes 2 □ No	28f Location (S	treet and Numb	er or Ru	ral Route Number,		
<u> </u>	il or Attending F after death. I Director: After d in by the funer	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,, , , ,		City or Town			,		
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t					death occurred at the ti							
	the He iin 24 the Fu	Medical	one)	niner: On the basis of and manner stat		or investigation, in my							
	To T Com	Σ	29b. Signature and title of certifier	01 -1-		29c. Licens	se number 5 7 630	I .	9d. Date signed June 15,				
)	8+1		- Spruero	Le Marie	elly, 4.	1)			anc 17,		· · · · · · · · · · · · · · · · · · ·		
	V		30. Name and address of person who Anuradha Arun,	·		ype, Print) .a Avenue,	Silver Sn	ring. MT	20902				
	Sta	te	31. Date filed (Month, Day, Year)	32. Regiŝtra	's Signature		op						
	Registr		JUN 182	UU/ Description	J. B.	Goods)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:28AM Roberta L. Proctor June 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly Prince George's Hospital Prince George's If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 💢 F Yrs. Director 578-58-0748 Jan. 2, 1937 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Ves 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code De o Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If Ifem 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be a rury or other traumatic event, the Medical Examiner must be a 4385 Benning Rd., NE 20019 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏ Yes 2 TNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 文 No Specify: Completed by Specify. Black 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Food Service Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Datcher Agnes Dorsey ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Proctor, Sr./Son 1811 Belle Haven Dr., #202, Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F
Important: If Ite
any Injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 6/19/2007 Landover, MD 21. Signature of Huneral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Physician Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner physician and is the burial-transit Hypertension Due to (or as a consequence of): Congestive Heart Failure use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ha 2□ No 2 1 No 1 ☐ Yes 1⊟ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funeral Director: / completely

31. Date filed (Month Day, Year) JUN 1 5 2007 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signat

59. Name and address of person who completed cause of death (Item 234) (Type, Print)

Medical

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

rive Chererly Mid 20785

29d. Date signed (Month, Day, Year)

6-13-07

07-04441

Michael Nikolau Pittas

. }			4.3	1000
E	U	1	li va	2

-	IVDE OIL	111111111111111111111111111111111111111	don made			_	
_	State of	Maryland	/ Department	of Hea	Ith and	Mental	Hygien

			agistrar 0-10-0/AIBD#JoFELTIFG CI	ficate of	Death		Reg. No. Date of Death	lo	3. Time of Death			
ি 'Çhys	sicia		L Decedent's Name (First, Middle,Last)				Month Da June 10, 200	y Year	1123 hrs			
Ex	amin		Michael N. Pittas	- 4	b. City, Town, or Lo	ocation of Death	JOHC 10, 200	4c. County of Deat	h			
			4a. Facility Name (if not institution, give street and number) eastbound Route 50 at mile marker 60		Easton			Talbot				
		=		st birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (N	/M/DD/YYYY) 9. Bi Forei	rthplace (State or			
Fune Direc		- 1	231–25–4849	Yrs	Months Days	Hours Min.	Dec.26,	1980	ountry) VA.			
Dilec	, LOI		231 92 7792 1X M 2 F 26			L	Dec.20,					
	ž.	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or Locati	ion			10d. Inside City Limits				
	ow any	Ì		ringfi	പ്പ		1 Yes 2 X No					
yland	onc sh	흱	VA Fairfax Sr 10e. Street and Number	<u> </u>	10f. Zip Code		10g.	Citizen of What Co	untry?			
e Mar	r 28s	Director	6293 WillowField Way		22150			USA				
ith the	s 23a or 28a-f show a e notified at once.		11. Marital Status 12. Was Decedent Ever in U.S	6. 13. Wa	s Decedent of Hisp	anic Origin? (Sp	ecify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,			
ath w	or items must be	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	IT Y	es, specify Cuban,		· ·					
ter de	, or		3 Widowed 4 Divorced If yes, Give Year		Yes 2X No			Specify: Wh 6b. Kind of Busines				
urs af	other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occupation	on (Give kind of w DO NOT use retir		6b. Kind of Busines	s/illidustry			
72 ho	al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	_				Auto Do	d.			
036 ithin '	ledic	ldm	12 1	Sr	op Manage	er 19 Mother's Name	(First, Middle, Ma	Auto Bo	dy			
5-0 led wi	othe the N	ខិ	17. Father's Name (First, Middle, Last)			Helen Z		,				
21215-0036 buld be filed within 7 Mental Hygiene.	marked c event,	Be	Nicholas Pittas	19h Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town, Sta	ate, Zip Code)			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hard Mental Hygiene.	is ma	10	19a. Informant's Name/Relationship (Type, Print) Nicholas Pittas— Father				Springf	ield. VA.	.22150			
MI nd 2 s alth a	m 27		20b.	Place of Dispo	sition (Name of cer		Date	20c. Location - City	or Town, State			
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.	Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 ST Burial 12 Cremation 3 Removal from State	crematory or o		61	14/07	Alexandri	a 177			
Page Page	ant: or ot		4 Donation 5 Other Specify:	A HITT	Cemetery Name and Address				a, Va. 22302			
Salt ermit.	npor		21. Signeture of Funeral Service Licensee					.Braddock				
			23a. Part I. Enter the disease, or conficient that caused the death	. Do not enter	the mode of dying,	such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and			
lysi	cian ical		failure. List only one cause on each line.			160			Death			
Exam			Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of	of):								
			h									
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):								
	-	Examiner	(Disease or injury that initiated Due to (or as a consequence of the c	of):								
pa	nsit	×	events resulting in death) Last	,								
760, icate be executed	physician and the burial - transit		UNPENDED AMENDED			_						
760, icate be e	ysicia buria	/Medical	IF FEMALE: 23c. If yes, outcome of pre	gnancy		_		23d. Date of del				
876 tificat	ng phy as the		23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic pregr	nancy	Month	Day Year			
Box 68	attending for use as	reician	past 12 months? 4 Pregnant at time of c	leath 5	Other (Specify)							
Bo	the a		Part II. Other significant conditions contributing to death but not	resulting in th	e underlying cause	given in Part I.			te to the cause of death?			
P.O.	signed by the be detached	3					1 Yes	2 🗸 No 3	Probably 4 Unknown			
T. E	n sign	1					24a. Was		re autopsy findings available r to completion of cause of			
ord w req	s been s	Completed						rmed? dea	th?			
ecc he la	ate has	3					1 🗸 Yes	2 No 1 V	Yes 2 No			
<u>~</u> ::	certificate	0 0	25. Was case referred to filedical			Other	sing Home 5	Residence 6	Other: Scene			
Division of Vital Records,	eath. or: After this certificate the fineral director, page		1 V Yes 2 No	ER/Outpati		jury at Work?	28d Describe	how injury accurred				
of Hara	After			1118 hrs		Yes 2 V No	Operator of	motorcycle inv	olved in collision			
ion	tor:		1 Natural 5 Pending Investigation 28e. Place of Injury - At		tract factory office		28f. Location (Street and Number	or Rural Route Number, City			
ViS or At	ifter d Direction by	S S	3 Suicide 6 Could not be 28e. Place of Injury - At			s ballaring, c.c.			arker 60, Easton, MD			
pital 🖸	neral	Tilled in by	4 Homicide determined (Specify) Major Ro	1 1 11 -		date and place a	and due to the cau	se(s) and manner a	s stated.			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif	within 24 hours after death To the Funeral Director:		29a Certifier Check only one) 29a Certifying Physician: To the best of my knowl Medical Examiner: On the basis of examination	edge, death o n and/or inves	ccurred at the time, tigation, in my opini	on, death occurre	ed at the time, date	and place, and due	e to the cause(s)			
5 #	withir To th	completely	one) 2 Medical Examiner: On the basis of examination and manner stated.			nse number		29d. Date signed	(Month, Day, Year)			
, °			29b. Signature and title of certifier			C.M.E.		June 11, 20	07			
a /		1	Clesk	02-1								
12 1	6	/1	30. Name and address of person who completed cause of death (It Ana Rubio MD. Assistant Medical Examiner	em 23a) 111 Pen	n Street, Baltir	more, MD 212	201					
1				110.5								
		Sta	te 31. Date filed (Month, Day Year) 32. Registrars Sign	112000	7							

			State of Maryland / [1 - State of Maryland / [1 - State AMEND#25&26,penMD,6/18/07,DPS,McCo	Departmen	t of Healt e of Dea	th and Mo	ental Hygi	iene	7 01000
			1. Decedent's Name (First, Middle, Last)				Date of Deatl	n Day Yee	3. Time of Death
	Physicia /Medic		Leon ROSENBLATT				June 13	, 2007	11:54 A M
7	Examin	er	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital		Town, or Locat)Iney	tion of Death		4c. County of De	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir				8. Date of Birth	9. Bi	irthplace (State or Foreign
	Director		207-12-1000 A 00	Yrs.	Days	urs IVIIII.	July 21	, 1926 Per	ountry) nnsylvania
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location					10d. Inside City Limits
	e Mary a-f sho ified a	ctor	Maryland Montgomery Silv	er Sprin	ıg				1 □ Yes 2 No
	or 28 be not	Director	10e. Street and Number 15100 Interlachen Drive #111	10f. Zip	Code 20906			og. Citizen of What C United St a	•
	be filed within 72 hours after death with the Marylan tial Hygiene. Indoctiver than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11 Manital Status 12. Was Decedent Ever in U.S.	13. Was Dece		c Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Am	nencan Indian,
9	after d or iten niner		1 Never Married Armed Forces? 1 Never Married Proces? 1 Yes 2 No	If Yes, spe		xican, Puerto F ecify:	Rican, etc.)	Black, Wh	white
003	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II	. Decedent's Usu				16b. Kind of Busines	s/Industry
-5-	in 72 n "nat Nedica	Completed	(Specify only highest grade completed)	(Give kind of wo life. DO NOT u	ork done during se retired)	most of workir	g		Silidustry
212	d with giene er tha	Som	5+	Roofer				Roofing	
altimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I marked other than "natural", or Items 23a or 28a-f show marke other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Be	17. Father's Name (<i>First, Middle, Last</i>) Morris Rosenblatt		18. N			Maiden Surname) Anna Pau	L
IZ S	d 2 should th and Mer 7 is marke traumatic	ပ္		. Mailing Addres	s (Street and N	umber or Rura			, Zip Code) 20906
∑ Ma	C1 00 - 10		Marilyn Rosenblatt, Wife 15			n Drive	, #111,	Silver S	pring, MD
ore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place o cemeter	of Disposition (Na ery, crematory or	me of other place)	D	ate	20c. Location - City of	or Town, State
Ē	permit. Pages Department of I Important: If Its any Injury or o		4 □ Donation 5 □ Other (Specify) Mt. Sh	aron Cen	netery	06/15	/07	Springfie:	ld, PA
Ba	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr	6 6	21. Signature of Furieral Solvice Lice,	Torchin	ısky Hel	brew Fu	neral H		
			23a. Part I. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mo	roll St de of dying, suc	ch as cardiac ò	Washin r respiratory arre	gton, DC	proximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	Jonys	onthy				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	of):		1			
		e.	fany, leading to immediate b. Due to (or as a consequence	ot):	4107	1) sec.	5-6		
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
90,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consequence	of):					
98760	ficate the physical p	edical	d						
×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	h 3⊟Ectopic p	vegnanov.			23d. Date of c	
P.O. Box	e deat he atte	sicis	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown	5 ☐ Other (s				Month	Day Year
<u>Р</u>	ires that the de signed by the a l be detached t		Part II. Other significant conditions contributing to death but not resulting it	in the underlying	cause given in F	Part I.	23e. Did tol	bacco use contribute	to the cause of death?
rds,	quires n signe ald be	d by	Renal Droubbaciery				1 □ Y	es 2⊉No 3□	Probably 4 Unknown
000	law require as been si 2 should t	plete	Non Hodgkins Lym	phone			24a. Was a		autopsy findings available o completion of cause of
Vital Records,	ding Physician: The law n After this certificate has t funeral director, page 2 s	Completed by	Hyperkalenia	i			perform	med? death 2. No 1 □ Y	?
<u>₹</u>	sician certifi rector,	Be	25. Was case referred to medical examiner? Hospital: ADJ No. 25. No.		Othor		Check onl on		
0	g Physer this eral di	J: To	27. Manner of Death 28a. Date of Injury 28b.		28c. Injury at Work?			ence 6 □Other (Si ow injury occurred	pecify)
Sign	ending sath. or: Aft he fun	atio	2 Accident investigation	Injury M	1 ☐ Yes	2 □ No			
Division or	i or Attendatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, for building, etc. (Specify)	arm, street, facto	ry, office		28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
ш	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it		29a. Certifier 1 ⊈ Certifying Physician : To the best of my knowledg						
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigatio	n, in my opinior	n, death occurr	ed at the time, d	late and place, and c	lue to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	29	c. License num	nber		9d. Date signed (Mo	
	10+1		20 Name and address of passes who completed owns of death (Name 200)	(Type Print)	1747	-///		June 14	
			30. Name and address of person who completed cause of death (Item 23a) Richard Weinstein (8104 PM	ice Philip	Drive	Olney	manla	rel Zo	832
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		•				
	Regist	rar	To Love St.	ADOU!					

			1- State Registrar	State of Maryland	d / Depa		ealth and M	lental Hyg		21259			
		4.4	Decedent's Name (First, Middle, Las.	")				2. Date of Deat	h	3. Time of Death			
	Physici		LEAH S	 RAVENSCR 	OFT			JUNE 1	5,2007	5:45 A ^M			
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	ocation of Death	O O IVID I	4c. County of Deat				
	Lydilli	ıçı	NATIONAL LUT	HERAN HOME		ROCK	VILLE		MONTGO	OMERY			
	Funeral		Social Security Number 6. Se	37	st birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth					
ĺ.	Director		Usual Residence of Decedent	□M 2ŽIF 84	Yrs.		Hours Will.	JÜLY 2	0,1922-M				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23e or 28e-f show any injury or other traumetic event, Ite M. dicel Ex. uits fr. units. In utility and once.	ctor	10a. State 10b. County MONTGO		Town or Lo	ROCKVIL	LE			10d. Inside City Limits 1∭ Yes 2 ☐ No			
	th with th	by Funeral Director	10e. Street and Number 9701- VEIRS	DRIVE		10f. Zip Code 20	850	1	0g. Citizen of What Co USA	untry?			
	dea ams	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White				
21215-0036	ours after ral', or Ita	by Fu	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No			Specify: WH				
2-0	72 hc	ted	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupat	ion uring most of worki	na	16b. Kind of Business/	Industry			
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	, 3 3		DEPT.S				
	ed wi	Completed	12		CLE	RICAL			OODWARD &	LOTHROP			
Maryland	2 should be filed withir and Mental Hygiene. is markad other than aumetic avant, Ire Ma	To Be	17. Father's Name (First, Middle, Last) RANDALL M.	RAVENSCROFT			18. Mother's Name		Maiden Surmame) ISCROFT				
	nd 2 sho alth and b 27 is ma	v s	19a. Informant's Name/Relationship (7. ROBERT RAVENSCR						City or Town, State, 2 EGE PARK,				
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent; If itam 27 is any injury or other tra once.		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of the place) 20c. Location - Cing Completery, crematory or other place) 20c. Location - Cing Completery, crematory or other place) 20c. Location - Cing Completery, crematory or other place) 20c. Location - Cing Completery, crematory or other place)										
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licens	600	22	2. Name and Address HYSONG	CO., IN	C.	NITE TARE	ı Da			
			23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only of	lications that caused the death.	. Do not en	ter the mode of dying	such as cardiac of	N A V E • or respiratory arr	, NW, WASH	Approximate Interval Between			
	Physician /Medical Examiner		snock, or neart failure. List only of Immediate Cause (Final disease or condition resulting in death)			liac d try dis				Onset and Death			
	49	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Curu Sonseque	ence of):	toy are	ale			20 years 20 years			
,092	eath certificate be executed attending physician and for use as the burial-transit	cai Examiner	that initiated events resulting in death) Last	c. Note that a consequence of the consequence of th	ence of):					ZO JANIS			
99	certificat Iding phy	ledi											
P.O. Box	requires that the death cer een signed by the attendin nould be detached for use	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3[□Ectopic pregnancy □ Other (specify)	 		23d. Date of del Month	ivery Day Year			
	res that igned by be deta	P /	Part II. Other significant conditions co	intributing to death but not resul	lting in the u	nderlying cause giver	n in Part I.	23e. Did tol	pacco use contribute to	the cause of death?			
ds	uires sigr	D	Urinary tro	et in fee	tion			1 🗆 Yı	es 2.⊈KNo 3.∏.Pr	obably 4 DUnknown			
Ö		ete						24a. Was a	n 24h Were au	itopsy findings available			
al Records,	The la ate has page 2							autops perfori 1 🗆 Yes	y prior to death?	completion of cause of			
Vital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death						
of	> .00 0	2	TUTES ZILYNO	1 Inpatient 2 E	R/Outpatie	IL 3 DOA	4 Minursing no		ence 6 Other (Spe	city)			
Division of	anding f eath, or: After he funer	cation	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work'	es 2 No	28d. Describe no	ow injury occurred				
Divi	tal or Att s after d al Direct ed in by 1	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, st	reet, factory, office		28f. Location (Si City or Town	reet and Number or Ri n, State)	ıral Route Number,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		vsician: To the best of my know iner: On the basis of examination and manner stated.									
	To the To the To the Comp	Ž	29b. Signature and title of certifier			29c. License	number		9d. Date signed (Mont				
			Lunder 1	melen mo		D003	06/2		June 15, 2	2007			
	(2)		30. Name and address of person who o		23a) (Type,	Print)	Rockvi	11e.Md	•				
_				32. Regigrar's Signar	I-VE	TIO DI•1	MOCW VI		· · · · · · · · · · · · · · · · · · ·				
	Sta Regist		31. Date filed (Month, Day (Year)	Security Pars State									

			1 - For State Registrar		State of N	/laryland	-	artmen rtificat			and M	lental Hy	/giene Reg. No.	American Ame	7	212	6 Ü
	Dhusisi		Decedent's Name (Firs	t, Middle, Last)							2. Date of De Month	eath Day	`	'ear	3. Time of D)eath
	Physici /Medio		HILE	10	· Ke	UNO	lds					June	-		07	2015	М
	Examir		4a. Facility Name (If not in	nstitution, give				4b. City,	Town, or	Location of	of Death		4c. (County of			
			Calvert	Mano	R			Lie	sing	Sun				Cec	il		
	Funeral		5. Social Security Number		x 7.7	Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Dec. 17	rth ay, Year)	9	Birthpl Coun	ace (State or try)	Foreign
	Director		221-07-8038		J IVI 2	9	b Yrs.]	Dec. 17	7, 19	10 N	lary	land	
	and *		Usual Residence of Dece 10a. State 10b.	County		10c. City	, Town or Lo	cation							11	Od, Inside City	Limits
	lanyl sho	5														1 ☐ Yes	
	the N	ect	Maryland (Cecil_		Nor	th Eas	10f. Zip	Codo			····	10g. Citiz	of \Mb	at Cour	tnu?	
	with	급	112 Old Elm	Road					21901							•	
	eath	Funeral Director	11. Marital Status	Road	12. Was Deceder	ot Ever in 11	S 12				ain? (So	Boifu Voc or N	Unite			S an Indian,	
	Item	Ę	1 Never Married 2	Married	Amed Force	s?	. 10.	f Yes, spec	cify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)			White,		
336	urs af		3 ☐ Widowed 4 ☐ □		If Yes, Give Year or Dates		46	1 ☐ Yes	2 K No	Specify:				Specify:	Whi	te	
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or Items 23a or 28e-f show event, the Medical Exartinar must be notified at	Completed by		ecedent's Edu	cation	17.13	16a, Dece	dent's Usua	ai Occupa	ation			16b. Kin	d of Busi	ness/Inc	lustry	
215	within 73 ene. than "n	ple	(Specify on Elementary/Secondary	ly highest grad	le completed) College (1-4o	r 5+\	(Give life.	kind of wo DO NOT us	rk done d se retired,	luring mos)	t of worki	ing					
2	filed withi Hygiene. other than ent, Ite M	E O	8	(0 12)	College (1-40	1 3+)	Cu	stodi	an				Pub]	lic S	Scho	ols	
Þ	be filed tal Hygid d other event, II	Be C	17. Father's Name (First,	Middle, Last)	,	-				18. Mothe	r's Name	e (First, Middle	e, Maiden S	Sumame)		•	
<u> a</u>	should be ad Mental marked o	10	Leroy Rey	nolds						Ma	arga	ret Bar	row				
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/R	elationship (T)	γρ ο , Print)		19b. Mailir	ng Address	(Street a	and Numbe	or Rura	al Route Numb	oer, City or	Town, St	ate, Zip	Code)	
_	1 and 2 Health em 27 I		Dorothy Re	yno1ds/	wife					d., 1	North	n East,	MD 2	21901			
Baltimore,	ges 1 ac t of Hea If item or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cre		Domoval from Star		ace of Dispo metery, crer	sition (Nan natory or o	ne of ther place	θ)		Date	20c. Loc	ation - C	ity or To	wn, State	
<u>Ĕ</u>	Pa nen nen nen rit:		`4 □Donation 5 □				ark Ce	emeter	rv	0	6-18	-2007	Newa	rk.	Dela	ware	
a	permit. Pag Department Importent: any injury c		21. Signatur Fineral	Service Licens	00 /							r. Foar					
<u>m</u>	Perr Dep Imp		Tran	1 6 /	ni duc							Newark					
	Physician		23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition	ease, or compl ire. List only o	ications that caus ne cause on each	ed the death line.	-	er the mod		g, such as		,	arrest,			Approximate Interval Betw Onset and De	een
	/Medical		resulting in death)		Due to (or a	as a con		-uel			(()				-	Jack	9
н	Examiner		Securation list condition		01	d	iendo	ral	Va	5 cal	our	Acu	der	6	5	ovova(419
	P ==	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate	Due to (or a	as a consequ	ence of).							•	1	·	1.3
	ocuter nd trans	ami	that initiated events		. Lev	eloral		heno	scl	ero	5,5				56	erect o	405
o,	e exe ian a urial-	E	resulting in death) Last			as a consequ	· .	_									•
8760,	death certificate be executed e attending physician and od for use as the buriat-transit	Physician/Medical			n Dy	per-t	ens:	o~/							2	everul	415
9	eath certifica attending ph I for use as t	Mec	IF FEMALE:												-		`
Вох	ath ce	an	23b. Was decedent pregrin the past 12 month	nant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy				2:	3d. Date		,	ear e
0	at the deg by the a tached for	sic	1 Yes 2 No	15:	4☐ Pregnant 9☐ Unknown		ath 5	Other (sp	ecify)					14101111	,	ouy it	,
Θ.	that the led by the detacher	Phy		conditions as	atribution to doub	but not room	leinn in the			n in Dani I		220 Did	tobooon us	o contrib	uto to th	e cause of de	ath?
S,	as du	b	Part II. Other significant		Atho				ause give	mmran.			Yes 2	1		ably 4 ⊟Ur	
0.0	w requires been signi should be	ted	en.	Brush	421100	1030	(41051					''-	193 2	140 3			
Vital Records,	2 S S	ompleted	019	age								24a. Was	psy	pric	or to con	ssy findings av	
=	Th ate pag	Co		,								pen 1 ☐ Yes	ormezi? No		ath?] Yes	2 No	
/ita	i cian : Th certificate rector, pag	Be	25. Was case referred to examiner?	<u> </u>	12-4					7000	of Death	(Check only	one)				
of	Physician: r this certific ral director,	ဥ	1 ☐ Yes 2 No		lospital: 1 ☐ Inpa		R/Outpatien			4 Nu		me 5 Res)	
Ü.	ding F	ion	27. Manner of Death Natural 5	Pending	28a. Date of In (Month, L	jury Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurrec	1		
<u>S</u>	tend death tor: the	icat	2 Naccident 3 Suicide 6 □	investigation Could not be	00 - Dia ()	alian Abba		М		/es 2 □ I		004 1	/C4===4 ===	Alexandra a	O		
Division	f or Attenation after deat Director:	Certification;	4 Homicide	determined	28e. Place of I building,	njury - At hor etc. (Specify,	me, tarm, str	eet, factory	, office			28f. Location (City or To	(Street and wn, State)	Number	or Hurai	Houte Numb	er,
	lospital I hours a unerel E		29a. Certifier	Cartifuing Phys	gicians To the har	et of my know	uladaa daati		na ab na aim	a data aa	d plane	and due to the				a and	-
	e Hospital 24 hours a e Funerel I	edical		ledical Exami	sician: To the bearings: ner: On the basis and manner	of examinati	ion and/or in	estigation,	in my op	oinion, dea	th occurr	ed at the time,	, date and	olace, an	d due to	the cause(s)	
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of	certifier _				290	. License	number			29d. Date	signed (Month, L	Day, Year)	
	⊢ s ⊢ ŏ		1000	8 20				7	100	15-C- 1	Cli		6	14/0			
			30. Name and address of	nerson who co	omoleted cause of	death (Item	23a) (Tune	Print)		583	2 4			1710	D		
1	ox IVA		DEILE: LAT		10 (7		LON(A	(5) (4.4	Die	SAM	Sun,	mn	210	317		
Ų.	Sta	te	31. Date filed (Month, Da	v. Year)		strar's Signati	ure	baselle	,	1 21 -			,	-/			
	Registr	ar	JU	14 T 9 5	007	Ever 1	15 19		-								

		For State	State of N	Marylan		artment of H		and Me		jiene leg. No.	17	21261
- 0 -		Registrar 1. Decedent's Name (First, Middle, Las	t)			imodio or i	Douth		2. Date of Dea	th		3. Time of Death
Physicia		Wanda Ruth Reynol	,						Month JUL	VE 15, E	Year 2007	2:22A M
/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number		ter	4b. City, Town, or	Amount.	of Death	n	4c. County of		imore
Funeral		5. Social Security Number 6. Se	ex 7.	Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		8. Date of Birth) Voorl	9. Birthpl	ace (State or Foreign
Director		235-66-0623	☐ M 2[X]F	63	Yrs.	Months Days	Hours	Min.	(Month, Day April	17 1944	Couin	t Virginia
P.		Usual Residence of Decedent		140-00						Land I have the Other Living		
arylar show d at	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f	Director	Maryland Ceci	l			Conowing	0					
vith ti	Ö	10e. Street and Number	_			10f. Zip Code				I0g. Citizen of W	nat Coun	try ?
s 23e	erai	1304 Liberty Grov	e Road 12. Was Decede	nt Ever in II	S 12 1	Vas Decedent of H		ain? (Snec	rify Yes or No-	USA 14. Bace	- America	an Indian.
ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	s?	.0.	Was Decedent of H If Yes, specify Cuba	an, Mexican	i, Puerto F	Rican, etc.)	Black	, White,	
urs af	þ	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🏋 No	Specify:			Specify:	Whit	:e
2 hou	ted	15. Decedent's Ed	ucation	- 1	16a. Dece	dent's Usual Occup	ation	t of workin		16b. Kind of Bus		
thin 7	ed l	(Specify only highest grade Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT use retired	d)	L DI WOIKIII	9			
ed wi	Completed	10			Home	emaker				Own I		
In all yielled ZIZIO-OOOO 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland Is marked other than "natural", or items 23a or 28a-f show Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)							,	Maiden Surname	∍)	
y could would marke natic	ပ္	George David John			406-84-10	ng Address (Street			es V. R		74-4- Zi-	Codel
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7				,						
1 and 1 and Healt em 2		Douglas Reynolds/ 20a. Method of Disposition	Son	20b. F		04 Libert sition (Name of matory or other place			ate Co	20c. Location - 0		
ages nt of ref		1 🕅 Burial 2 □ Cremation 3 🗆		ite			1				•	
it. P. artme		4 □ Donation 5 □ Other (Specify 21. Signature of uneral Service Licen		Wes		ingham C . Name and Addre			-2007	Colora,	Mary	land
permi Depar Impo any Ir		> tuh (MIL		R	T. Foar	d Fun	era1	Home,	P.A.	rp 0.1	011
		23a. Part1. Enter the disease, or comp	olications that caus	sed the deat	h. Do not ent	1 S. Que er the mode of dyir	en_SI ng, such as	cardiac or	respiratory ar	g_Sun,_P rest,	1D_71	Approximate
Physician	9 2	shock, or heart failure. List only in Immediate Cause (Final			A THE	ARCTION	ı					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	d	as a conseq		HUCLION		_			-	
Examiner			,			Y DISEA	SE					
ENTER	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of j.							
cuted nd ransi	Examine	Cause (Disease or injury that initiated events	c									
ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to (or	as a conseq	uence of):							
cate be executed only sician and the burial-transit	dical		.d									
The law requires that the death certific are law requires that the death certific are been signed by the attending page 2 should be detached for use as	/Mec	if FEMALE:	220 if was outpoo	mo of orogo	anov							
attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcom 1 ☐ Live birth 4 ☐ Pregnan	n 2 ☐ Feta	al death 3	Ectopic pregnancy Other (specify)	у			23d. Date Mor		ry Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow		ieairi 5L							
that the ded by		Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use contr	ibute to th	ne cause of death?
uires uires Id be	d by	CHRONIC OBSTRUC	TIVE PUL	MONARY	DISE	EASE			101	′es 2 No	3 🗌 Prob	ably 4 Unknown
w red beer shou	lete	RENAL FAILURE	roo ma						24a, Was	an 24b. V	Vere auto	psy findings available inpletion of cause of
he la e has	Completed	RENAL FAILURE							autop	moned.? Id	nor to cor leath? □Yes	
an: T an: T tifficat or, pa		25. Was case referred to medical					26. Place	of Death	1 Yes (Check only o		□ Yes	2 NO
ysicii is cer direct	To Be	examiner?	Hospital: 1 Inp	atient 2	ER/Outpatier	nt 3 DOA Oth	or:			lence 6 □Othe	er (Specif	y)
ig Ph ter thi		27. Manner of D. ath	28a. Date of	Injury Day Year)	28b. Time o	f 28c. Injui				low injury occurre		
ath. Pr: Af	Certification:	1 Natural 5 Pending 2 Accident investigation			.,.,		Yes 2□	No				
r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	injury - At he etc. (Special	ome, farm, sti	reet, factory, office		2	8f. Location (S City or Tox	Street and Numbern, State)	er or Rura	l Route Number,
ital o irs aft rai Di			-									
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 ✓ Certifying Ph (Check only 2 ☐ Medical Exan	niner: Of the basi	s of examina		h occurred at the ti vestigation, in my						
thin 2 the mple	Med	29b. Signature and title of certifier	nd manner	stated.		29c. Licens	se number			29d. Date signed	(Month	Day, Year)
F. ¥ F. 00	_	1/ 7	7				356			-1		
		30. Name and address of person who	completed course	of death (Ite-	n 23a) /Tuna		e- hear hear hear			June 1	16	an T
4				. 760		SLER DRI	(VF	TOWS	ON. MA	RYLAND	21	204
Sta	ate	21 Date filed (Month Day Year)		istrar's Signa		hacks	- T from	1 tor VV h				
Registr		JUN 15	(UU/)	PARA D	15 14	The same of the sa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear ORLEAN RIDER 06 24 07 0822 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month Day, Year) Jun 21, 1918 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2x F Director 232-26-2391 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" — any injury or other traumatic excessions. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Allegany Cumberland X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 724 Avondale Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Snecity. Specify: white Completed by ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bobbin & Spin Dept. Celanese Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac W. McDonald Bassie G. (Davis) McDonald ပ 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Code) 4321 Pioneer Place, SE Port Orchard WA 98366 19a. Informant's Name/Relationship (Type. Print) grdaughter Bonnie Lawson 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Rocky Gap Veterans Cemetery 6/28/2007 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Nam Scarbelle Puner la Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 2 No 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1. Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of a 29d, Date signed (Month, Day, Year) 10033280 June 25

Registrar DHMH 17 Rev 1/2001

10

State

625 Kent Avenue, Cumberland, MD, 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

·D.

32. Registrar's Signature

6upte

0 2 2007

K. 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 12, 2007 ear **Physician** Dale Smith 11:00pm Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Chevy Chase Chevy Chase Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/26/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Days Hours 170-16-1197 86 Knox, PA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours atter death with the Marylan al Hygiene to other than "natural", or Items 23a or 28e-1 show vent, the Modical Exercitations the collined at 1 ☐ Yes 2 No MD Montgomery Kensington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9830 LaDuke Drive 20895 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1⊠Yes 2□No 1942− If Yes, Give Year or Dates: 1045 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Corporate Weighing Suprv. Republic Steel permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Importent: If Item 27 Is marked other it
any injury or other traumatic avent, In
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Starr William Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delores R.Smith/Wife 9830 LaDuke Drive Kensington, Md. 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem 6/15/2007 Beltsville, Md. * 4 □ Donation 5 □ Other (Specify) Funeral Service Licentee 21. Signature PHITTP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis /Medical Due to (or as a consequence of) Examiner Respiratory Distress Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Possible Aspiration Pneumonia Due to (or as a consequence of): Box 68760 Hypothyroidism Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 ☐ Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Inknown Completed <u>Hypertension</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Sisk Sinus Syndrome 1 ☐ Yes 2 XNo Division of Vital I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 XNo 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier t 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D20274 June 12,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd. Bethesda, Md 20817 Kirti Vohra MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 8 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

JUN 1 8 2007

3. Time of Death

1 X Yes 2 No

Year

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2007 2122 1, ALVIN SMITH JUNE /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. HOM 2 F 223-56-8730 63 Director 12-28-1943 VIRGINA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiry or other traumatic event, the Medical Examiner must he acceptance. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director PRINCE GEORGE LANHAM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8425 HAMLIN STREET #104 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE MILK PLANT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS SHAUL SMITH HELEN LEE THORTON ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLY BROWN/FRIEND 8425 HAMLIN STREET #104 LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State FT. LINCOLN CEMETERY 06-18-07 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events and resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2K No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29c. License number

29b. Signature and title ocertifier 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type Print) Name and address of person who co HOSPITA 31. Date filed (Month, Day, Year) 32. Registrar's S

State Registrar

			Please Type or Prin					-	_	le.	
			State of Ma	aryland / [lental Hy	giene		
			1 - State Registrar		Cer	rtificate of l	Death	2. Date of De	Reg. No.	1	3. Time of Déath
	Physicia	an	1. Decedent's Name (First, Middle, Last) Hettie K. Sibley					Month June	Day	Year	9:45 P ^M
1	/Medic		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death	Julie	4c. County o		9:45 P
)	Examin	er	Brooke Grove Nursing Co	enter		-	Spring		Mont	gom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)	9. Birthp	place (State or Foreign
ı.	Director		230-30-0861 1 M 2 TF	92	Yrs.			Jan. 20	7, 1915	Vir	ginia
	land w t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Lo	cation			-		10d. Inside City Limits
	Many -f sho fied a	tor	Maryland Montgomery	Damas	scus	3					1 □Yes 2X No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	23a c ust b	ral	25200 Woodfield Road			208			U.S.A.		
	er dez items ner m	Funeral	11. Marital Status 12. Was Decedent I Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ 1 □ Yes 2 □ Ye	Ever in U.S.	13. V	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	- Americ , White,	can Indian, etc.
30	rs aft r, or xamii	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 N If Yes, Give Year or Dates:	NO	1	1 ☐ Yes 2 📉 No	Specify:		Specify:	Wh	ite
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's Education	16a	. Deced	dent's Usual Occup	ation	ina	16b. Kind of Bus	siness/In	dustry
7	thin 7 e. an "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	+)			during most of work i)	nig .			
7	e filed within al Hygiene other than " vent, the Me		8 17. Father's Name (First, Middle, Last)	1	Home	maker	19 Mothor's Nam	o /Eirot Middlo	Own H		
land	t be fi	Be c	John Cope				Mary	Gibsor		7	
>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healm and Mental Hyglene in the 23a or 28a-f show then 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Ţ.	19a. Informant's Name/Relationship (Type. Print)	196	o. Mailin	ng Address (Street	and Number or Rui			State, Zij	o Code)
S S	1 and 2: Health a: tem 27 is other trau		Mary J. Martin - Daughter	22	2505	Frederi	ck Road,	Clarks	burg, Ma	rv1	and 20871
ore,	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Rurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place o cemete	of Dispo	sition (Name of matory or other plac	ce)	Date	20c. Location - C		
Ĕ	Рад ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	Salem			emetery 6				e, Maryland
Baitimor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licenses		M	Name and Addre Ioleswort	ss of Facility h-William	s P.A.,	Funera1	Hor	ne
		1,510,	23a. Part1. Enter the disease, or complications that caused	the death. Do			ge_Road,_			land	Approximate Interval Between
	Dhysisian		shock, or heart failure. List only one cause on each lir Immediate Cause (Final	ne.	,		3,	,	,		Onset and Death
3	Physician /Medical		disease or condition resulting in death) a Due to (or as	4501 Va		D Pre	Pironu				dey
	Examiner		Sequentially list conditions b.								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	of):						
_6	execut and al-tran	xan	that initiated events c.	a consequence	of):						
08/PO	death certificate be executed e attending physician and of for use as the burial-transit	_									
	rtificat ng phy as th	Physician/Medica	IF FEMALE:								
X Q Q	ath ce ttendii or use	ian/l	23b. Was decedent pregnant 1 Live birth	2 Fetal death		Ectopic pregnancy	/		23d. Date Mon		ery Day Year
	00	ysic	1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	time of death	5L	Other (specify)					22,
7	law requires that the de as been signed by the 2 should be detached		Part II. Other significant conditions contributing to death be	ut not resulting i	in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco use contri	bute to I	the cause of death?
ecords,	quires n sigr uld be	ed by						1 🗆	Yes 2 No	3□ Pro	bably 4 □Unknown
ပ္ပ	law re as bee 2 sho	Completed						24a. Was	an 24b. W	/ere aut	opsy findings available ompletion of cause of
r	The ate has page	Com						perfo	ormed? d	eath?	2□ No
VItal	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:			Oth	26. Place of Deat				
0	£ 20 € 0	. To	1 Ves 2 No Hospital: 1 Inpatie		utpatien Time of	nt 3 DOA Oth	4 Lanursing H		dence 6 Othe		fy)
	nding th. : After	tion	1 X Natural 5 □ Pending (Month, Day 2 □ Accident investigation	Year)	Injury	Wor	k? Yes 2 □ No	Edd. Describe	now injury occurre	i.u	
Division	Atter rector by the	Certification:	· · · · · · · · · · · · · · · · ·	ury - At home, fa	arm, str	reet, factory, office			Street and Numbe	r or Rui	al Route Number,
ב	ital or irs afte ral Dii lled in										
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis on and manner sta	f examination a							
	ro the	Med	29b. Signature and title of certifier	atod.		29c. Licens	e number		29d. Date signed	(Month	Day, Year)
)	6		My Ash			D	0055694		June 18	, 20	007
•	5		30. Name and address of person who completed cause of d	eath (Item 23a)	(Type,	Print)					
	Sta	10-	Alok Mather, M.D. 400 31. Date filed (Month Day Year) 9 2007 32. P. Gistr.	00 01ney	y-La	vtonsvil	le Road,	01ney,	Marylan	d Z	20832
	Sta Registr		JUN 1 9 2007	We D	1						
_											

			For State Registrar	State of	Marylan		artment of I				iene eg. No.	1 7	21257
			1. Decedent's Name (First, Middle,	Last)		-				ate of Deat	th Day	Year	3. Time of Death
1	Physici /Medio		Fern B.	Smith					_	une	16.	2007	9:40 A ^M
	Examin		4a. Facility Name (If not institution, g	give street and numb	er)		4b. City, Town,	or Location of	of Death		4c. Count	y of Death	
			Edenton	6	A (1- 1/1-)	14 to 1-4 1	Fred	erick If Under	24 Hrs. 0. D.			ederi	
Н	Funeral Director		5. Social Security Number 163–22–8920	.Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. 92	Yrs.	Months Days		Min. (M	ite of Birth lonth, Day, Q	^{Year)} 1914	Coun	ace (State or Foreign try) sburgh
			Usual Residence of Decedent		72				Dec	0,	1714	1100	SDUIGH
	nylan how	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					10	Od. Inside City Limits
	Ba-f s	cto		erick		Fred	erick						1 ☐ Yes 2 No
	vith th	Directo	10e. Street and Number				10f. Zip Code				0g. Citizen of		
	s 23e	eral	5800 Genesis L	ane	ant Ever in II	C 112 1	2170		ining (Capaifu V		United	State Ce America	
S)	filed within 72 hours after death with the Maryland Hygiene. sther than "neturel", or Items 23e or 28e-f show ont, the Modical Examitter must be multiled at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2	es?		Was Decedent of f Yes, specify Cub			etc.)		ack, White, e	
8	rel', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1□Yes 2XNo	Specify:			Speci	ity: W	hite
2	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occu kind of work done	durina mos	t of working		16b. Kind of E	Business/Ind	ustry
121	within	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NDT use retire	•			,		
N 0	Hygie Hygie ther t	e Co	17. Father's Name (First, Middle, La	st)		1	Homemaker		er's Name (First	Middle M		Own Ho	me
ylan	b d la la la la la la la la la la la la la	To B	James A. Bake	r					lizabet			,	
Baltimore, Maryland 21215-0036	s 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship Eric Schardt / 1			1	og Address <i>(Stree</i> Sandrae I				-		Code)
Jore	Pages 1 and of He		20a. Method of Disposition 1 Durial 2 XCremation 3		ate C	emetery, crer	sition (Name of natory or other pla		Date		20c. Location		
			 4 □ Donation 5 □ Other (Spe 21. Signaty of Funeral Service Lice 		Sta		Cremato		-19-200 v Stau		Funera		Maryland
eg H	permit. Departr Imports eny inji		Vountrey (Stauffe	1		1621 O _I	ossum	town Pi	ke, I	Frederi		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplication that cau ly one cause on eac	sed the death h line.	n. Do not ent	er the mode of dy	ng, such as	cardiac or resp	iratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	100								Chiset and Death
L	/Medical Examiner		rooming in dodsiy	Due to (or	as a consequ	uence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):							
	cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.									
Ó	e exectan an an urial-tr	Exa	resulting in death) Last		as a consequ	uence of):							
8760	death certificate be executed e attending physician and of for use as the buriat-transit	dlcal	•	d									
9 ×	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregna	incv	<u> </u>				224 5		
Box	death atten	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐Live birth	n 2 ☐ Fetal It at time of de	Ideath 3□	Ectopic pregnand Other (specify)	y				ate of deliver onth	y Day Year
o.	to the de by the a tached	hysl	9 Unknown	9□ Unknow	n								
ກັ	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the u	nderlying cause gr	ven in Part I	. 2:	3e. Did tob	oacco use cor	tribute to the	e cause of death?
g	w require been sign		Demen	r G					— <u>I</u> L	1 □ Ye	es 2□No	3 ☐ Proba	ibly 4 □Unknown
Vital Records,	- O 75	Completed							24	4a. Was ar autops	y	prior to con	sy findings available
r =		Con							1(perform ☐ Yes 2	ned? No	death? 1 ☐ Yes	2□No
VIT	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0.1		of Death (Che				
ō	Phys this ral dii	. To	1 Yes 2 No 27. Manner of Death	1 □ Inp		ER/Outpatien 28b. Time of	t 3 DOA	ny at	rsing Home 5		ence 6 ∐Ot ow injury occu)
0	ading f th. : After s funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day Year)	Injury	Wo	rk?]Yes 2 □		0001100 110	w mijary ooca	TTOG	
Division	ol or Attendia after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not	be 28e. Place of	Injury - At ho , etc. (Specify	me, farm, str	eet, factory, office	-	28f. Lo	cation (Sti	reet and Num	ber or Rural	Route Number,
5	itel or rs afte rel Dir led in	Cert	- I Tollicido	building	, etc. (Specif)					ly or rown	i, State)		
	ne Hospitel or Attending n 24 hours after death. he Funerel Director: After pletely filled in by the fune.	edical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examinat	tion and/or inv	estigation in my	oninion, dea	th occurred at the	he time da	ate and place	and due to	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				29c. Licen:	se number		29	9d. Date sign	ed (Month, E	ay, Year)
			MY .	NY			100	604	フ	4	/18/	2007	7
	6		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	1		-			21702
			Hemen Shall 31. Date filed (Month, Day, Year)	4 Mb	650	- Iho	mas	John	ison b	V.,	Fred	enica	CMD
	Sta Registr		JUN 19	2007	Surar S Signal	B A	need!	_					21702 C MD

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 25, SIMPSON JR. 2007 11:00 PM RAYMOND JOHN June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jarrettsville Harford 4012 Security Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6/12/1929 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F 78 214-26-0280 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits item 27 ie marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Jarrettsville MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 United States 4012 Security Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes Give Year or Dates:Korea 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within all Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 4 Installer Supervisor Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: If Item 27 ie marked oth any Injury or other traumatic event Be Winifred John Raymond Simpson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 John R. Simpson III 4012 Security Lane (Son) Jarrettsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) timore National 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Euneral Sergice Ligen ee E.G. Kurtz & Son Funeral Home. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each use. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thriver Pailcore @ month. Physician 40 /Medical Due to (or as a consequence of) Examiner cero sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1☐ Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) s. Reguraj. mp 0053720 06 27 2007 041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pd, #100, Below, MD 21014 boosenta.2 602, s. Acaguaraj. mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 02 2007 Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 12:45 P.M Judith Irene Torgerson June 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6414 Old Landover Rd. Landover Prince Georges 8. Date of Birth (Month, Day, Year) June 27, 1947 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Months Days Hours 1 □ M 2 🖫 F 057-38-4296 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Prince Georges Maryland Landover 1 √Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6414 Old Landover Rd. 20785 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Librarian Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Franklin McNeal ဥ Jean Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Torgerson/Husband 6414 Old Landover Rd. Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 11 4 Donation 5 ☐ Other (Specify) Washington, D.C. 2007 Center Pame and Address of Facility Columbia Mortuary Services 21. Signature WFuneral Service I censee 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last carcinoma of the Bread IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other_significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation

Physician /Medical **Examiner**

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

72 hours after

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division or Vital

Examiner burial-trar physician Physician/Medical the for use detached ģ <u>م</u> Completed certificate has page 2 Be ျ

1 Matural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

requires that the death certificate be execu this funeral Hospital or Attending P 4 hours after death, Funeral Director: After t After 1 Certification: the filled in by Hospital

within 24 hours a To the Funeral C Medical

State Registrar 29b. Signature and title of certifier

6 Could not be determined

29c. License number

1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

NE

20002

ed cause of death (Item 23a) (Type, Print)

and manner stated.

1011

Capital

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Iniury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Ma	arylan		artment <i>rtificate</i>			nd Mental	Hygier Reg. 1	- 2 0 0 1	7 2127
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gloria J. Tayl	.or						2. Date of Month		Day 2007 Year	3. Time of Death 11:50P M
)	Examin		4a. Facility Name (If not institution, give s Southern Maryla	treet and number) and Hosp	oita	L	4b. City, To	wn, or	Location of I			4c. County of Death	1
	Funeral Director				je (In yrs. I 58	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min. 8. Date of Month	of Birth n, Day Yea 1e 29	9. Birth	nplace (State or Foreign untry) a •
	e Maryland Ba-f show tiffed at	Director	Usual Residence of Decedent 10a. State D . C . 10b. County			, Town or Lo shingt							10d. Inside City Limits 1 X es 2 No
	th with th 23a or 24 ust be no	al Dire	1150 Sumner Roa	d SE			10f. Zip C 20	ode 020				Citizen of What Cou	untry?
036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ M If Yes, Give Year or Dates:		1	Vas Deceder f Yes, specify I ☐ Yes 2☐		spanic Origin n, Mexican, I Specify:	n? (Specify Yes o Puerto Rican, etc	or No- .)	14. Race - Amer Black, White Specify: B1	, etc.
21215-0036	d within 72 hogiene. sr than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5	ō+)	16a. Deced (Give life. L Nur	lent's Usual (kind of work DO NOT use	Occupa done d retired)	tion uring most o	of working	1.1	Kind of Business/I	ndustry
Maryland		To Be C	17. Father's Name (First, Middle, Last) James Wilkins		•					Name (First, Mi nnie	_{ddle, Maid} Gaff	*	
	d2 tra		19a. Informant's Name/Relationship (Type Ramon Taylor -									y or Town, State, Z orf Md.	
saitimore,	Pages 1 am ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. P	lace of Dispo emetery, cren ount C	natory or other livet	er place		ne19,0	7 Wa	Location - City or I shingto	n, D.C.
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	Lober	Su							.C. 2000 313 6th	St. N.W.
	Physician /Medical Examiner		23a. Part1. Errer the disease, or complic shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		inom	a Lin	er the mode o	of dying	j, such as ca	ardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death
ď	- 43/6	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):							
08/00,	ficate be executed physician and sthe burial-transit	edical Exa	resulting in death) Last	Due to (or as	a consequ	ence of):							
C. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3]Ectopic preg] Other <i>(spe</i> c					23d. Date of deliv	very Day Year
ecords, P	equires that en signed b ould be deta	by	Part II. Other significant conditions cond Immune Wray by	ributing to death b					n in Part I.				the cause of death?
VITAL Meco	The law recate has be page 2 sho	Completed	, , , , , , , , , , , , , , , , , , ,							<u> </u>	Was an autopsy performed? es 2 □ I	prior to condeath2	opsy findings available ompletion of cause of
\ \ \	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 22 No	ospital: 1 Inpatie		ER/Outpatien	4 2 DOA	Othe	r-	f Death (Check o			
vision or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, after this certificate has completely filled in by the funeral director, page 2 to the property of the funeral director, page 2 to the funeral director, page 2 to the funeral director.	-	27. Many of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	iry	28b. Time of Injury		Injury Work		28d. Descr		6 ☐Other (Specifury occurred	ify)
DIVIS	tal or Atters as after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injubulding, etc.	ury - At ho c. <i>(Specify</i>	me, farm, stre	eet, factory, o	office		28f. Locati City o	on (Street r Town, Sta	and Number or Rui ate)	ral Route Number,
	the Hospi nin 24 hou the Funer npletely fill	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physical Examin	cian: To the best er: On the basis of and manner sta	f examinat	wledge, death ion and/or in	vestigation, ir	n my op	inion, death	place, and due to occurred at the t	ime, date a	and place, and due	to the cause(s)
) ^	To To	Σ	29b. Signature and the first which	MD					number			Date signed (Month)	
	(11)		30 Name and address of person who cor	nnleted cause of d	eath (Item	23a) (Type, I	Print)						

CR (4)

State Registrar Richard Palmin mo 1328 Jonthan Avienne SE Sinte 310 Was hing hin DC 20032

31. Date filed (Month, Day, Year)

JUN 1 8 2007 Liquid D. Spirit

	1 = For State Registrar	State of Maryland		t of Health : e <i>of Death</i>		iene 007	21272
Physician /Medical Examiner	4a. Facility Name (If not institution, give	Thomp SON street and number)	1	Town, or Location		Day Year / 8 Z 00 4c. County of Dea	th
Funeral Director	5. Social Security Number 6. Se 220-42-5020 Usual Residence of Decedent				24 Hrs. 8. Date of Birth (Month, Day)		A thplace (State or Foreign buntry) entucky
deeth with the Maryland me 23e or 28e1 ehow rmust be notified at	10a. State 10b. County		Town or Location Havre de		1	0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
D36 urs after url; or its by Full	3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1966·	1 ☐ Yes	2 ™ No Specify:		Specify:	erican Indian, se, etc. White
Ind 21215-00 be filed within 72 hot tel Hygiene, "natural other than "natural event, the Medical Event, the		College (1-4or 5+)	(Give kind of wo life. DO NOT us	rk done during mos se retired) gineer	st of working er's Name (First, Middle, I	Enginee	,
Maryland Maryland and 2 should be fill and Mental Hy 27 is marked out rireumatic even To Be (John E. Thomps 19a. Informant's Name/Relationship (7) William L. Thomp	rpe, Print)		(Street and Numb	ary E. McBr er or Rural Route Number treet, Easto	, City or Town, State,	
Page Page ury or III	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State 20b. Pla	ce of Disposition (Narmetery, crematory or o	ne of ther place) Co., Inc	Date 06/21/2007	20c. Location - City or West Ches	Town, State
Balt permit. Departr Importu	21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compishock, or heart failure. List only o	11	123 S	Washing	Il Smith Fungton St., Ha	avre de Gr	Pace, MD Approximate Interval Between
B760, Wedical also be executed hysician and the burial-transit his burial-transit lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DUE to (or as a consequence of the to (or as a consequence of	maligna ence of): J				Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be example to a state of the last been signed by the attending physicien bage 2 should be detached for use as the buria completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 ☐Ectopic pr			23d. Date of de Month	livery Day Year
Il Records, P.O. Box: The law requires that the death cercate has been signed by the attendir page 2 should be detached for use Completed by Physician/N	Part II. Other significant conditions co			-			robably 4 Unknown
of Vital Rec nysician: The lav nis certificate has I director, page 2:	25. Was case referred to medical examiner?				autops perform 1 Yes 2	ned? death? 2□No 1⊠Yes	atopsy findings available completion of cause of 2 No
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification; To Be Comp	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	М	8c. Injury at Work? 1 ☐ Yes 2 ☐	No	ow injury occurred	
Divi	4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - At hon building, etc. (Specify) sician: To the best of my know	ledge, death occurred	at the time, date an	City or Town	ause(s) and manner as	sstated
To the Hospital within 24 hours a To the Funeral completely filled	29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	290	. License number	2	9d. Date signed (Mont	h, Day, Year)
0)	30. Name and address of person who or ALAN SWEATM 31. Date filed (Month, Day, Year)	ompleted cause of death (Item AN HARE 32. Red strar's Signatu	23a) (Type, Print)	WAC HE	DIPITAL L	fauer de	G2465

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			For State Registrar	State of Mary		rtificate of		Re	eg. No.	0107
	Physicia /Medic		1. Decedent's Name (First, Middle, L Richard	Tull	4-1- 			2. Date of Deat Month	14 2007	3. Time of Déath
1	Examin Funeral	er		orce at the	Lake In yrs. last birthday)	4b. City, Town, o	IS DUTY If Under 24 Hrs Hours Min.	8. Date of Birth	4c. County of Death Wi Corr Year) 9. Birthr County	lace (State or Foreign
	Director		213-42-0884 Usual Residence of Decedent	1 XM 2 ☐ F 6	55 Yrs.	Wortus Days	Hours Will.	Feb. 7,]	1942 Mary.	ľánd
	Maryland	tor	10a. State 10b. County Maryland Somers		0c. City, Town or Lo	risfield			1	0d. Inside City Limits 1 XYes 2 ☐ No
	h with the	al Director	10e. Street and Number 69 Somers Cove Ap	artments		10f. Zip Code	21817	1	0g. Citizen of What Coul U.S.A.	ntry?
036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21	within ene. than "	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Employed	during most of work d)	ting	16b. Kind of Business/In	
Ē	2 should be filed and Mental Hygis is marked other aumatic event, the	To Be C	17. Father's Name (First, Middle, Las Norris James Tu						Maiden Surname) Sterling	
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship Tonya Sterling	(Daughter)	2622	Bunting	Road - Po	ocomoke (1851
more	ury Pa		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	⊔Hemovai from State	20b. Place of Dispo cemetery, cre. Sunpyridge I	Memorial Pa	erk 6/18	3/07	20c. Location - City or To	•
Bal	permit. Departn Importa any inju			dshaw, or.	1 3	<u>06 W. Mai</u>	ess of Facility Sons Fur n St Ci	<u>cisfield</u>	, MD 21817	
<i>)</i>	The law requires that the death certificate be executed	edical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	consequence of):	TRUCTION	R PULL	ionary b	DESRASE	Interval Between Onset and Death
O. Box 6	he death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	cy		23d. Date of deliv Month	ery Day Year
ds, P.O	uires that the de signed by the a d be detached f	þ	Part II. Other significant conditions	contributing to death but I	not resulting in the u	underlying cause given	ven in Part I.	23e. Did to	bacco use contribute to	he cause of death?
		Completed						24a. Was a autops perfor	sy prior to co	opsy findings available ompletion of cause of
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	nt 3□ DOA Otl	her	th (Check only or	ne)	(6.1)
Division or	ing Ph I. After th funeral	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time o	of 28c. Inju		28d. Describe h	ow injury occurred	-
Ď N	ital or Attencis effer death rai Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d building, etc.				City or Tow		
	e Hospital 24 hours e E Funeral letely filled	Medical		Physician: To the best of aminer: On the basis of e and manner state	xamination and/or in					
	Se Se									
	To the within 2 To the comple	Me	30. Name and address of person where the state of the sta				se number		29d. Date signed (Month	

6 EB State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 8 2007

ASTAL HUSPICA
32. Registrar's Signature

April ORIGINAL

			For State Registrar	State of	Maryland / De	•	ment of Helicate of D			iene	17 2.127	1
	Dhyoisi		Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	3. Time of Death	
	Physici /Medic	al	Marion	Haney	Trevas		0: **		Jun 25,	2007	1 1:47am ™	-
	Examin		4a. Facility Name (If not institution, Beverly Living Co	enter of Cu	umberland	C	city, Town, or Cumberla	and		4c. County of Allegar	ny	
ı	Funeral Director		076-20-8289	5. Sex 1 □ M 2 ☐ F	7. Age (In yrs. last birth) 85 Yr	Mo	Under 1 Year onths Days	Hours Min		1921	Birthplace (State or Foreign Country) England	7
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						10d. Inside City Limits	;
	e-feh	ctor	MD Alleg	any	Cur	mber	rland				1√2 Yes 2 □ No)
	with the	Dire	10e. Street and Number 10690 Rose Brie	r Court		1	Of. Zip Code	1502	10	og. Citizen of W US	,	
	ns 23	eral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. Was			Specify Yes or No- rto Rican, etc.)	14. Race	- American Indian,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel; or frams 23a or 28e-f ehow event, the Madical Examenational De notified at	Completed by Funeral Director	1 Never Married 2 Marrie 3 Wildowed 4 Divorced	Armed For d 1 Tyes If Yes, Giv Year or Da	2No		s, specify Cubar Yes 2 No	Specify:	rto Rican, etc.)		white, etc.	
200	72 hou natura	ted	15. Decedent's (Specify only highest	Education	16a. D	ecedent'	's Usual Occupa	tion	ndring	16b. Kind of Bus		
121	vithin 7 ne. hen "r	mple	Elementary/Secondary (0-12)	College (1	-4or 5+)		d of work done di NOT use retired) Lor	aring most or we		wn hom		
9	filed v Hygie other t		12 17. Father's Name (First, Middle, L	ast)	hom	ema		18. Mother's Na	me (First, Middle, M			_
/lan	Mental Mental urked o	To Be	Clifford Haney					Lillian	McCubbin	Haney		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", or Itams 23a or 28e-f ehow empty injury or other treumetic event, the Madical Examinat must be notified at an once.		19a, Informant's Name/Relationshi John McMullen				^{ddress} (Street a. pect Squa		lural Route Number, Cumbe		State, Zip Code) MD 21502	
altimore,	of Hest of Hest if item or othe	·	20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from 5	20b. Place of D cemetery,	cremato.	ry or other place				City or Town, State	
ij	it. Pag rtment rtent; njury c		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Septice).	ecify)	Scarpelli		ral Home,			Cresapt	own MD	
Bal	Depar Impor eny ir		21. Signatu or uneral service).	100	111.	22. Na	Scarpelli 108 Virgi		lome, PA e: Cumberla	and MD 2	1502	
	Pnysician /Medical Examiner		23a Party Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a Co	aused the death. Do no ach line. YENVU VCV. or as a consequence of	scul	ne mode of dying		c or respiratory arre		Approximate Interval Between Onset and Death Week	
ص م.	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leadin, to immediate cause, enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of							
8760,	cate be ohysicia the bu	dicai		d					· · · · · · · · · · · · · · · · · · ·			_
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐Live bi	come of pregnancy irth 2 Fetal death ant at time of death wn		opic pregnancy her (specify)			23d. Date Mon	o of delivery th Day Year	
Δ.	uires that I signed by Id be deta	by	Part II Other significant condition				lying cause give	n in Part I.		acco use contri	bute to the cause of death?	1
Vital Records,	ilcien: The law requir certificate has been si rector, page 2 should	Completed							24a. Was ar autops perform	y pr ned? de	Vere autopsy findings available fror to completion of cause of eath? ☐ Yes 2☐ No)
/ital		BeC	25. Was case referred to medical examiner?						eath (Check only one	,		_
ot	Phys this ral di	- L	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 🔲 li	npatient 2 ER/Outp		DOA Othe	4 V Nursing	Home 5 Reside			
on	nding Fath. r: After e funera	ation	1 Actural 5 Pending 2 Accident investiga	(Mont	h, Day Year) Inji	ury	Work	?` es 2 □ No		,,	-	
Division	for Atternation	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place	of Injury - At home, farming, etc. (Specify)	n, street,	factory, office		28f. Location (Str City or Town		er or Rural Route Number,	
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the xaminer: On the ba	best of my knowledge, asis of examination and/ er stated.	death occ	curred at the time	e, date and plac inion, death occ	e, and due to the ca curred at the time, da	use(s) and mar ate and place, a	nner as stated. nd due to the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier	1-			29c. License			_	(Month, Day, Year)	
65			N	polom				3328	0	June	25, 2007	
	10		30. Name and address of person v		e of death (Item 23a) (T	ype, Prin	TO DI	ECI	misas	LAND.	MD 21502	
	Sta		31. Date filed (Month, Dav. Year)	32 R	egistrar's Signature						- 01000	_
	Registr	CII	JUL U Z	ZUU/	France St. E	Look	2					

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar		State of M	aryland		irtment of F rtificate of I		and Mental	Hygier Reg. I		/ 5107
	Physici	an	Decedent's Name	(First, Middle, Las	st)			imodio or	Boain	2. Date of Month	of Death	Day Year	3. Time of Death
	/Medi	al	4a. Facility Name (If	Ya-Fei	Wan			4b. City, Town, o	r I coation o		ne 10,		1:45 P M
	Examir	er	10524 Democ		s street and numper)	,		Potoma		Death		Montgomer	
	Funeral Director		5. Social Security Nu 216-88-4244	umber 6. S	ex 7. Ag □ M 2 X F	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min, (Monti	of Birth n, Day, Yea 18, 19	ar) 9. Bir	thplace (State or Foreign ountry) Lna
	land ow It		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	a-f she	ctor	MD	Montgomer	у	Rock	ville						1 □Yes 2 X No
	or 28	Director	10e. Street and Num	nber		-		10f. Zip Code	-		10g.	Citizen of What Co	ountry?
	eath w is 23a nust l		4714 Kemper	Street	12. Was Decedent	Ever in II S	12 1	20853	lionanio Orie	rin? (Specify Vec.		ited State:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lnjury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☒ Widowed		Armed Forces 1 Tyes 2 1 Yes, Give Year or Dates:	?		Yes, specify Cuba	Specify:	gin? (Specify Yes c i, Puerto Rican, etc	.)	Black, Whi	
15-0	"natu	letec	(Speci	15. Decedent's Ed ify only highest gra	lucation de completed)		(Give i	ent's Usual Occup	durina most	of working	16b.	Kind of Business	/Industry
712	withir jiene.	Completed	Elementary/Secon	ndary (0-12) 12	College (1-4or	5+)		00 NOT use retired H omemaker	1)			Own Home	
	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (First, Mi	ddle, Maid	len Surname)	
yla	ould to Ment Marked Marked	일	Yei	Wang					Shu		-ee		
Maryland	nd 2 st Ith and 27 is n traun		19a. Informant's Nat		lype. Print)			g Address <i>(Street :</i> rickyard Ro		or or Rural Route N	umber, Cit 2085 4		Zip Code)
	of Hea	3	2Ca. Method of Dispo	osition		20b. Plac	ce of Dispos	sition (Name of natory or other place		Date		Location - City or	Town, State
Baltimore,	Page Iment tant: If			Cremation 3 ☐ 5 ☐ Other (<i>Specif</i>)	Removal from State	' l	incoln	Crematory	6	5/18/2007		ntwood, Man	
Ball	permit Depart Import any Inj once,		21. Signature of Hur	neral Secrice Licen	the see		118	Name and Addres New Han	ss of Facility pshire	Hines-Rina Ave., Silv	ıldi Fu er Spi	neral Homering, MD 20	e, Inc. 1904
	Physician /Medical Examiner		shock, or hear Immediate Cause (F disease or condition resulting in death)	it failure. Jonly i	blications that cause one cause on each line. a. Inanition Due to (or as b.	on		er the mode of dyin	g, such as	cardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death 3 months
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list con if any, leading to imreause. Enter Under Cause (Discussion that initiated events resulting in death) La	mediate lying njury ast	cDue to (or as	· ·							
O. Box	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 🗷 9 ☐ Unknown	nonths?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal d	eath 3 🗆	Ectopic pregnancy Other (specify)	1		_	23d. Date of de Month	livery Day Year
rds, P.	w requires that the de been signed by the a should be detached f	ρ	Part II. Other signific	cant conditions co	ontributing to death b	out not resulti	ng in the un	derlying cause give	en in Part I.				o the cause of death?
Division or Vital Record		Completed								—	Was an autopsy performed?	? death?	utopsy findings available completion of cause of 2 \square
Ħ	s certif	o Be	25. Was case referre examiner? 1 ☐ Yes 2 🗶 N	-	Hospital:	ent 2□EF	2/Outpationt	2 DOA Othe		of Death (Check o		X	Daughter's
sion or	ding P	-	27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Da	ıry 2	8b. Time of Injury	28c. Injun Worl	yat k? Yes 2∐N	28d. Desci		iury occurred	Daughter's Residence
DIV	ital or Atten rs after death ral Director; led in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	Zoe. Place of Inj	ury - At home tc. (Specify)	e, farm, stre	et, factory, office		28f. Locati City of	on (Street Town, Sta	and Number or Rate)	ural Route Number,
	To the Hospital or Al within 24 hours after d To the Funeral Direc completely filled in by	Medical	(Check only gone)	2 ☐ Medical E)kam	ysician: To the best niner: On the basis of and manner st	of examination	edge, death n and/or inv	estigation, in my o	pinion, dea	d place, and due to th occurred at the t	the cause ime, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
		2	29b. Signature and	itle of certifier	11			29c. License	5120			ne 14, 200	
	10	-	30. Name and addre	ess of person who o	completed cause of d	leath (Item 2	3a) (Type, F		J120			ine 14, 200	•
					, 6316 Democ			ethesda, Ma	ryland	20817			
野野	Sta Registr		31. Date filed (Month		32. Registr	ar's Signatur	e Le de						

sician	nogiou a 1	vuadzu, pei	MD , 6/18/07	,DPS,McCc	Cei	rtificate of	Death		Re	g. No.	I was I had I
	 Decedent's Nan 	ne (First, Middle,	Last)	Wilso					. Date of Death Month	Day Ye	3. Time of Deat
dical		Edwin	` <i>D</i> `		2/1	45 Cit 7	1		June	1 2003	
niner	1158	+ Scaggsvi	give street and num Storia Group	p Home		4b. City, Town,				4c. County of I	
al	5. Social Security		. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year		24 Hrs. 8	Date of Birth		tgomery Birthplace (State or Form Country)
or	242-16		1 ⊠ M 2□F	86	Yrs.	Months Days	Hours	Min.	(Month, Day, 1		orth Carolina
	Usual Residence	of Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Lin
To Be Completed by Funeral Director	Maryland	Montgom	oru				D. 1	-			1 ★ Yes 2 □
Director	10e. Street and Nu		cry			10f. Zip Code	oma Parl	K	10	g. Citizen of Wha	it Country?
		Westmorela	and Avenue				20912			U.S	
by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 ⊠ Married 4 □ Divorced	Armed For	2		Vas Decedent of f Yes, specify Cub I Yes 2 2 No			y Yes or No- an, etc.)	14. Race - /	American Indian, White, etc. White
Completed	(Spe	15. Decedent's	Education grade completed)			lent's Usual Occu kind of work done		t of working	16	6b. Kind of Busin	
P P	Elementary/Sec		College (1	-4or 5+)	life. L	OO NOT use retire	ed)	. or working			
Ş	12 17. Father's Name	/First Middle La	est)			Sales	10 Motho	oda Nama /F	Tirot Adidada Ada	Applia: aiden Sumame)	nce Parts
Be e			nder Wilson					Erwin S		uden sumame)	
၉	19a. Informant's N				19b. Mailin	g Address (Stree				City or Town, Sta	te, Zip Code)
	Joan P.	Wilson -	Wife							, Maryland	
	20a. Method of Dis		☐Removal from S	20b. Pla	ace of Disno-	sition (Name of natory or other pla Maryland		Date		Oc. Location - City	
y		5 Other (Spe		Vet	msville erans C	Maryland emetery	State	6/7/200	07	Crownsvil	le, Maryland
900	21. Signature of F	uneral Savida Liv	ensee Lewe	ou _	HÍ	Name and Addr nes-Rinald 800 New Ha	ss of Facilit i Funer mpshire	ral Home	e, Inc.	Spring, N	Maryland 20904
	23a (Part1. Enter shock of hea immediate Cause disease or condition resulting in death)	(Final on	a. Due to (c	Thun C							Approximate Interval Between Onset and Death
			,	or as a conseque	ence of):		100 000	Cocco		/	_
dical Examiner	Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying rinjury s	с	or as a consequent	ence of):						
dical Examin	cause. Enter Und Cause (Disease or that initiated event resulting in death)	entying injury s Last of pregnant months?	C	or as a consequence of pregnanth 2 ☐ Fetal of the contract time of deal	ence of): ence of): ence of):	Ectopic pregnanc Other (specify)				23d. Date of Month	
by Physician/Medical Examin	Cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 9 Unknown Part II. Other signi	entying sinjury s. Last Last tregnant months?	c	or as a consequence one of pregnanth 2 ☐ Fetal on the at time of dealers.	ence of): ence of): ence of): acy death 3 ath 5	Ectopic pregnanc Other (specify)	y		23e. Did tobar	23d. Date of Month	delivery Day Year e to the cause of death?
Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state that pregnant months?	c. Due to (c) d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknown	or as a consequence one of pregnanth 2 ☐ Fetal on the at time of dealers.	ence of): ence of): ence of): acy death 3 ath 5	Ectopic pregnanc Other (specify)	y		23e. Did tobar 1 □ Yes 24a. Was an autopsy performe	23d. Date of Month 2 No 3 24b. Were prior deatt	delivery Day Year e to the cause of death? Probably 4. Unknow
Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months?	c. Due to (c) d	or as a consequence of pregnanth 2 Fetal curt at time of dealers	ence of): ence of): ence of): ticy death 3 ath 5 titing in the un	Ectopic pregnanc Other (specify) _ derlying cause giv	y ven in Part I. 26. Place	of Death (C	23e. Did tobar 1 Yes 24a. Was an autopsy performe 1 Yes 25e heck only one)	23d. Date of Month 2 No 3 24b. Were prior deatt	delivery Day Year e to the cause of death? Probably 4 Onknot e autopsy findings availat to completion of cause of the cau
To Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury stant months? No ficant conditions for the months?	C. Due to (c) d. 23c. If yes, outce 1 1 1 ve bir 4 Pregna 9 Unknows contributing to deal to the contribution of the contribut	or as a consequence of pregnanth 2 Fetal curt at time of dealers with the consequence of the consequence o	ence of): ence of): ence of): acy death 3 ath 5	Ectopic pregnanc Other (specify) _ derlying cause gives 3 □ DOA Other 28c. Injur Wor	yen in Part I. 26. Place 18: 4□ Nur yat k?	of Death (Crsing Home	23e. Did tobac 1 Yes 24a. Was an autopsy performe 1 Yes 2 E heck only one)	23d. Date of Month 2 No 3 24b. Were prior deatt	delivery Day Year e to the cause of death? Probably 4 Unknot a autopsy findings availat to completion of cause of the caus
To Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months?	C. Due to (c) Due	or as a consequence of pregnanth 2 Fetal of the pregnanth of the pregnanth of determined the pregnanth of	ence of): ence of): ence of): ence of): ency death 3 ath 5 ting in the un ence of):	Ectopic pregnanc Other (specify) _ derlying cause gives 3 □ DOA Other 28c. Injur Wor	y yen in Part I. 26. Place aer: 4 □ Nur	of Death (Crsing Home 28d	23e. Did tobau 1	23d. Date of Month 2 No 3 24b. Were prior deatt 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	delivery Day Year e to the cause of death? Probably 4 Onknot e autopsy findings availat to completion of cause of the cau
o Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months? No ficant conditions fred to medical for the months from the months fred to medical for the months from the first free free free free free free free fre	C. Due to (c) Due	or as a consequence of pregnanth 2 Fetal of the contract time of decision with the contract time of decision with the contract time of decision with the contract time of decision with the contract time of decision with the contract time of decision with the contract time of time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time of the contract time	ence of): ence of): ence of): ence of): ency death 3 ath 5 titing in the un eR/Outpatient 28b. Time of Injury ne, farm, stre	Ectopic pregnanc Other (specify) _ derlying cause give 3 □ DOA Other 28c. Injur Wor M 1 □ et, factory, office	26. Place 186°: 4 □ Nur y at k? Yes 2 □ N	of Death (Crsing Home 28d	23e. Did tobar 1 Yes 24a. Was an autopsy performs 1 Yes 24beck only one) 5 Tesidence Describe how Location (Stree City or Town, Street City or Town,	23d. Date of Month 2 No 3 24b. Were prior death 27No 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1	delivery Day Year e to the cause of death? Probably 4 Onknow e autopsy findings availate to completion of cause of the cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of the completion of the cause of th
Certification: To Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months? No ficant conditions for the medical for the	Due to (c) c. Due to (c) d. 23c. If yes, outcome to the pregnance of t	ome of pregnanth 2 Fetal cunt at time of deawn ath but not result patient 2 Eliniury, Day Year) of Injury - At hom g, etc. (Specify)	ence of): ence of): ence of): ence of): ticy death 3 ath 5 titing in the un eR/Outpatient 28b. Time of Injury ne, farm, stre	Ectopic pregnanc Other (specify) derlying cause give 3 DOA Other 28c. Injun Wor 1 Let, factory, office 29c. Licens	26. Place 196: 4 Nur 19	of Death (Crsing Home 28d	23e. Did tobac 1 Yes 24a. Was an autopsy performe 1 Yes 2-beck only one) 5-1 Tesidence Describe how Location (Stree City or Town, Street City or Tow	23d. Date of Month 2 No 3 24b. Were prior deatt 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1	delivery Day Year e to the cause of death? Probably 4 Onknor a autopsy findings availal to completion of cause of Probably 4 Onknor a received the cause of th
edical Certification; To Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months? No ficant conditions for the medical for the	Due to (c) c. Due to (c) d. 23c. If yes, outcome to the pregnance of t	ome of pregnanth 2 Fetal cunt at time of deawn ath but not result patient 2 Eliniury, Day Year) of Injury - At hom g, etc. (Specify)	ence of): ence of): ence of): ence of): ticy death 3 ath 5 titing in the un eR/Outpatient 28b. Time of Injury ne, farm, stre	Ectopic pregnanc Other (specify) derlying cause give 3 DOA Other 28c. Injun Wor 1 Let, factory, office 29c. Licens	26. Place 196: 4 Nur 19	of Death (Crsing Home 28d	23e. Did tobac 1 Yes 24a. Was an autopsy performe 1 Yes 2-beck only one) 5-1 Tesidence Describe how Location (Stree City or Town, Street City or Tow	23d. Date of Month 2 No 3 24b. Were prior deatt 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1	delivery Day Year e to the cause of death? Probably 4 Onknor a autopsy findings availal to completion of cause of Probably 4 Onknor a received the cause of th
edical Certification; To Be Completed by Physician/Medical Examin	cause. Enter Undicause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	injury state to pregnant months? No ficant conditions for the medical for the	Due to (c) c. Due to (c) d. 23c. If yes, outcome to the pregnance of t	ome of pregnanth 2 Fetal cunt at time of deawn ath but not result patient 2 Eliniury, Day Year) of Injury - At hom g, etc. (Specify)	ence of): ence of): ence of): ence of): ticy death 3 ath 5 titing in the un eR/Outpatient 28b. Time of Injury ne, farm, stre	Ectopic pregnanc Other (specify) derlying cause give 3 DOA Other 28c. Injun Wor 1 Let, factory, office 29c. Licens	26. Place 196: 4 Nur 19	of Death (Crsing Home 28d	23e. Did tobac 1 Yes 24a. Was an autopsy performe 1 Yes 2-beck only one) 5-1 Tesidence Describe how Location (Stree City or Town, Street City or Tow	23d. Date of Month 2 No 3 24b. Were prior deatt 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1	delivery Day Year e to the cause of death? Probably 4 Onknow e autopsy findings availate to completion of cause of the ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0107 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death 2^{Day} 2007 **Physician** 1656 Henry Robert Williams June M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Clements Island Museum Pier Colton's Point St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours XIXM 2□ F 258-74-6602 60 Director 04-16-1947 Savannah GA Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dt-al Examiner must be notified at Director DC ▼ TV Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 620 Mississippi Ave SE #10 20032 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Black ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 11 Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Henry Robert Williams Lillie Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #10 SE Washington DC 20032 : If item 27 Is or other tra Esther Williams /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ₹ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lincoln Cemetery 6/11/2007 Suitland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of FacilityPope Funeral Home 2617 Penn Ave SE Washington DC 20020 2. a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 120 bable **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician Physician/Medical the, IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ed by the signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsv page perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 1XYes 2∐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) St. Clen an Ta this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

Division or Vital Records, P.O. Box 68760, or Attending Physician:

s after dec. Hospital 24 hours a within 24 hou

To the Fune

completely fi

Registrar

William Boyd, MD 25365 31. Date filed (Month. **JUN 18**

4 ☐ Homicide

(Check only

29b. Signature and title of certific

determined

Point Lookout Rd Leonardtown MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

State

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D14285

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 49 PM Month Year **Physician** 2007 JUNE WHITAKER. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctor's Hespito NRAM 8. Date of Birth (Month, Day, Nov. 02, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1944 Enfield, N.C. 1**Ճ**M 2□ F 62 238-70-0458 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State th and Montal Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traur attic event, the Medical Examiner must be notified at 1¥ Yes 2 No Directo Mitchellville Prince Georges Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20721 12508 Woodsong Lane Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 21 Married Specify: Black altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Carpet Installer 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Grady Wade Russell Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 134 Eagle Head Dr. Ft. Washington, Md. 20744 Tanisha Whitaker /Daughter Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) June 17,2007 Enfield, N.C. Cedarview Cemetery 22. Name and Address of Facility Alexander S Alexander S D Alexander S Alexand 21. Signature / Funeral Service License 20747 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has how minimal to the Funeral Director. attending physician and for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1☐ Yes 2 No 25. Was case referred to medical examine. 26. Place of Death (Check onl one Certification: To Be Other: Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year) State JUN 1 5 2007 Registrar

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

200/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item 1- State #5 per fh,eb,6-19-07 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6213 06 2001 Webster Henry Northam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner NICOMICO Keginal M Dalisburi ender edical eninsula If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 05-6583 6. Sex **Funeral** Min. Months Days Hours Yrs. 201**-**0506583 95 03/12/1912 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21853 USA 27177 Mt. Vernon Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify Specify. ģ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mill Worker Boat Construction 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Webster Helen Mae Northam ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Neil Webster/Son 12062 Jeffrey Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Asbury U.M. Cemetery 6/19/2007 Mt. VErnon, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service/Licenses Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD /23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coroner /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 4⊡Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗌 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Hatural 5 Pending investigation 1 Yes 2 No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral C 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and in

State Registrar

EB

Brea

31. Date filed (Month, Day, Year)

TIEUM

2007

JUN 1

DHMH 17 Rev 1/2001

120

of person who completed cause of death (Item 23a) (Type, Print)

32. Re strar's Signature

100 E. CANKOLI

			1 = For State Registrar	State of	Maryland / De <i>C</i>	partment of F ertificate of			ene g. No.:	21280
	Physici /Medio		1. Decedent's Name (First, Middle, La Earl Wayne	st) Whitm	ore			2. Date of Death Month June	Day 2007	3. Time of Death 8: 10 A.M
	Examir		4a. Facility Name (If not institution, giv 821 Lanvale St.	e street and numb	per)		r Location of Death	1	4c. County of Death Washingt	on
	Funeral Director		211 30 2100	Sex 7. ✓ M 2□ F	Age (In yrs. last birthd: 68 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 21		place (State or Foreign ntry) ryland
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Md. Was	hington	10c. City, Town or	Location Hagers to	own		1	10d. Inside City Limits 1 □ Yes 2 □ No
	with the 1 3s or 28e-	i Director	10e. Street and Number 821 Lanvale S			10f. Zip Code	21740	10	og. Citizen of What Coul	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28e-f ehow way injury or other treumatic event. It is Madical Examt and must be recilled at once.	by Funerai	11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No	3. Was Decedent of Hif Yes, specify Cubin 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: W	
21215-0036	within 72 hou ene. then "nature the Mudical E	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. De	cedent's Usual Occup ive kind of work done b. DO NOT use retired Painter	during most of wor	king	6b. Kind of Business/In	
Maryland 2	uld be filed dental Hygi rked other tic event.	To Be Co	17. Father's Name (First, Middle, Last, Cyrus A. Whitmor					ne (First, Middle, M	laiden Sumame)	CETOII
	ind 2 shou alth and N 27 is mai		19a. Informant's Name/Relationship (ailing Address (Street			City or Town, State, Zip	Code)
altimore,	Pages 1 a ment of Hei ant: if item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		20b. Place of Discemetery, of	sposition (Name of trematory or other place of the control of the	(a) Jun		Oc. Location - City or To Smithsburg	
Balt	permit Depart Import eny in		21. Signature of Funeral Service Licer	Davis	s M01414	J.L. Davis	•	Home Smi	525 Bradbur ithsburg,Md	y Ave. .21783
8760, ×	Physician passented with the principle of the principle o	al Examiner	23a Part: Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or	mhosi		us	c or respiratory arres	st,	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate tee has been signed by the attending phy.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 Fetal death nt at time of death	3 Dectopic pregnancy	,		23d. Date of deliver	ery Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions of	contributing to dea	th but not resulting in the	e underlying cause giv	en in Part I.		acco use contribute to t s 2 □ No 3 □ Prot	
Vital Records,		Completed						24a. Was an autopsy perform	ed? death?	psy findings available mpletion of cause of
	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗆 Inp			er: 4 Nursing H	th Check only one	nce 6 Other (Specif	(y)
Division of	Attending Physiclan: or death. ector: After this certific by the funeral director.	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	n	Injury 28b. Time Day Year) Injur	y Wor	yat k? Yes 2 □No	28d. Describe how	w injury occurred	
Σ	To the Hospitel or Attending Phwithin 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	O	4 Homicide determined	286. Place of building	f Injury - At home, farm, , etc. <i>(Specify)</i>			City or Town,		
	To the Hospital or A within 24 hours after To the Funerei Direction proprietely filled in by	Medicai	(Check only 2 Medical Exar	nysician: To the b niner: On the bas and manne	est of my knowledge dissof examination and/or stated.	investigation, in my o	pinion, death occu	rred at the time, dat	te and place, and due to	o the cause(s)
)	T will		29b. Signature and title of certifier		7		181714		d. Date signed (Month) 6/26/07	
	10		30. Name and address of person who	AVEN	UI= MA	FERSTON	JN, M	10.017	42	
38	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Reg	pistrar's Signature	parks				

07-04708	
Troy D Wallace	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 20, 2007 0553 hrs Medical Examiner Troy Darien Wallace 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Peninsula Regional Medical Center Salisbury 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday **Funeral** Months Hours Min Days Director Country) 41 1X M March 4. 1966 Maryland 213-90-9692 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 x No 28a-f show items 23a or 28a-f shoust be notified at once. Eden MD Somerset 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 14084 Backbone Road 21822 Funeral 14. Race - American Indian, Black, 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 1 X Yes No Black Widowed Divorced If Yes, Give Year 01, 1985-86 Yes 2 x No specify: Specify event, the Medical Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Ealtimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hour
Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natt
injury or other traumatic event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Janitorial Service Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Wallace Sandra Lee Gale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Wallace/Father 400 Bailey Lane - Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 June 26, 07 St. Charles UMC Cemetery Chance, Maryland Donation 5 Other Specify. 22. Name and Address of Facility 21. Sign-ture of Funeral Service Licens Salisbury, Maryland 21801 Jolley Memorial Chapel, P.A. - 1213 Jersey Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause of /Medical Death Cocaine intoxication complicating atherosclerotic cardiovascular Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): 11SeaSe Sequentially list conditions Due to (or as a consequence of). if any, leading to inimediate cause. Enter Underlying Cause LUL (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial AMENDED 27,28a-f, perME, g869, 7/5/07 TI The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy this certificate has performed? death? ✔ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: Natural 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: Pending FND 6/20/2007 FND 5:17 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide or Town, State) 14084 Backbone Rd. Eden, MD (Specify) house Homicide 29a, Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month,

State Registrar

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9869 7-17-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 6:35p 27 2007 Edith Brown June /Medical Hilda 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Keswick Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sequely Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs. Director 212-62-0947 04 MD 98 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other then "neturel", or iteme 23a or 28a-f ehow vent, the Medical Examinat must be notified at Marylan 1 ☐ Yes 2 X No Director Catonsville Baltimore MD115 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21228 U.S.A. 1901 Cedar Circle Drive Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black Š 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner 12th grade Beauty Salon ith and Mental Hygid 27 is marked other r traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Malinda Price Robert Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand nt of Heelth a : If item 27 is or other tra Catonsville, 1901 Cedar Circle Drive, Jacqueline Hall-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of important: If eny injury or soce. 7/6/07 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heen vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute DUV /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Syndroine certificate hes lirector, page 2 s 1 Tes 2 □ No director, 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this After thi 28a Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident tor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ To the Hospital or At within 24 hours after d Yo the Funerel Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Me 29c. License number Time 28, 2007 completed cause of de (f (Item 23a) (Type, Print) Balto. md ales St. Bunc

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 7

6701

32. Registrar's Signature

			1 - For Amend Items	State of M 23c,25 p	larylar er u k	nd / Depa 2, g869 6	artmen Wicat	t of H 2/8/1	ealth a	and M	lental Hy	/giene Reg. No.		
	L. M. o		Decedent's Name (First, Middle, Las	t)							2. Date of D		V	3. Time of Death
	Physici /Medi		DANIEL BUS	CH							JUNE	Day		
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c.	County of De	ath
-			HARBOR HOS	PITAL			BA	LTI	MOR	E				
	Funeral Director		5. Social Security Number 6. S 2.36-09-0490	x 7. A M 2□ F	ge (In yrs. 91	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D July 6	ay, Year)		inthplace (State or Foreign Country) t Virginia
	pu ,		Usual Residence of Decedent		10- 0	T								
	aryla ehov	_	MD 10b. County N/A			ty, Town or Lo								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	Director			Bal	timore								Α
	Nith t	声	10e. Street and Number				10f. Zip					_	zen of What (Country?
	s 23	Frai	2048 Grinnalds Ave	PNUE 12. Was Decedent	t Ever in 11	C 42.1			annia Osi	ain 2 (Ca	naifu Van au N	U.S		nerican Indian,
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 is marked other than "natural", or items 23e or 28e-f ehow injury or other traumatic event, it a Muclical Examinar must be notified at a.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces 1 Dyes 2 If Yes, Give 1 Year or Dates.	2		f Yes, spec	ofy Cuba	Specify:	gin? (Spi n, Puerto	ecify Yes or N Rican, etc.)		Black, Wh	ite, etc.
21215-0036	2 hou	ed	15. Decedent's Ed		134	16a. Deced	dent's Usua	al Occupa	ation			16b. Ki	nd of Busines	s/Industry
15	n n	Completed	(Specify only highest gra	de completed)	E.)	(Give	kind of wor DO NOT us	rk done d se retired	luring mos)	t of work	ing			,
212	yiene giene r tha	E	Elementary/Secondary (0-12)	College (1-4or	3+)	Forem	an					Gene	eral Mo	otors
	illed other	0	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, Ita M.	To B	Felix Busch						Mary	Dap	kus			
ary	should and Men s marke rumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or Or Rura	al Route Numi	ber, City o	Town, State	Zip Code)
	1 and 2 Health a tem 27 I		Teborah Potts/Daug	hter		2025	Harma	an As	renue	Ba1	timore	MD 2	1230	
ore	of He fitem		20a. Method of Disposition 1 2 Burial 2 Cremation 3	Damas al from Chat	20b. F	Place of Dispo Veteral	sition (Nan	ne of ther place	9)		Date		cation - City of	r Town, State
Ĕ	Pages nent of ant: If it ary or o		4 Donation 5 □ Other (Specify			vetera ownsvi	n Cem 112	eter	y ¦C)6 - 20	2007	Crov	vnsvil	le, Maryland
Baltimore,	permit. Pag Department Importent: I any Injury o		21. Sunati re of Funeral Service Licen	La	eali			d Addres Fur ammor	s of Facility neral	Homerry	e of La Rd. La	ansdo ansdo	wne wne MD	21227
ž.,			23a. Part1. Enter the disease, or corp shock, or heart failure. List only	ilications that cause	dine deat	h. Do novent	er the mod	e of dying	g, such as	cardiac (or respiratory	arrest,	WITC TID	Approximate Interval Between
	Physician		Immediate Cause (Final											Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as		TION uence of):								ONE HOUR
in a	Examiner	1		b. GAST	TRA I	NTEC	TIAL	Δ,	RI	FFI	SINGI		11	and Ham
1000		ner	if any, leading to immediate	Due to (or as	s a conseq	NTES uence of):		1		<u> </u>	- 11401	17		01-01-041
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Colon	Canc	er				\ ^	PPROVED BY N	-DICAL EX	AMINER	
ó	a exe	EX	resulting in death) Last	Due to (or as	s a conseq	uence of):				1/	DOROVED BY N	EDIO		
8760,	ate be nysici	dical	(d					CERTIF	MATIONA	AL11-			
9		Jed	IE EEMALE.						CELL)				
P.O. Box	The law requires that the death certific Ite has been signed by the attending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	Ectopic pr Other (sp					2	23d. Date of d Month	elivery Day Year
σ.	that led b		Part II. Other significant conditions co	entributing to death I	but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	se contribute	to the cause of death?
p	uires sign Id be	d by	CORONARY A	RTERY	DIS	EASE					1 🗆	Yes 2[⊒No 3) (1	Probably 4 Unknown
Vital Records,	w requir been s should	Completed	Colored Colored								24a. Wa	. 20	24b Wara	autopsy findings available
Re	The lav	ם	COLUIO CHIVE		-						auto	opsy ormed	prior to	completion of cause of
a		မ C	25. Was case referred to medical								1 Tes	2 N o	1 🗆 Ye	es 2 No
	Physicien: r this certific ral director,	o Be	examiner?	Hospital:		ED/0		Cthe	·c·		Check only			
o	Phys r this ral di		27. Manner of Death	28a. Date of Inj		ER/Outpatien 28b. Time of		'A	4 🗆 Nu		me 5 Res			ecify)
on	ding I h. After funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	м	8c. Injury Work	? ′es 2 🔲 I				, 0004.104	
Division of	I or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Płace of In building, e			eet, factory					(Street and		Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledical C	29a. Certifier 1 X Certifying Ph	vsician: To the best iner: On the basis of and manner st	of examina	wledge, death	occurred estigation,	at the tim in my op	e, date an einion, dea	d place, th occurr	and due to the ed at the time	cause(s) , date and	and manner place, and de	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and atle of certifier				290	. License	number			29d. Date	e signed (Moi	nth, Day, Year)
)	. ,,,) (lals	PHYSICI	ANI			RE	S OC	00		Ju	NE . 16	, 2007
/			30. Name and address of person who co			n 23a) (Tvne	Print) T				AMEN			,
4	11)		3001 SOUTH	HANOVE	R 57	REET	BA	LTI	MOG	77	MA	2122	5	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regist			,	- 1 1	1.701	, _ ,	ا مو ا			
1.5	Registr	21	HH 0 2 2007	Real	1.00	100								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Month 06 **Physician** 2007 9:03 P MZelma Jestine Butler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5801 Chinquapin Pkwy Apt. B If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 XF 73 220-30-0725 Director July 9, 1933 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1 MYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 5801 Chinquapin Pkwy Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specifican American Saltimore, Maryland 21215-0036 1 ☐ Yes 21XXNo þ 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 College (1-4or 5+) self-employed childcare provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret McNeill James Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Chinquapin Pkwy. Apt. B; Baltimore, MD 21239 19a. Informant's Name/Relationship (Type. Print) Rosalind Haines / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/2007 Baltimore, Maryland Metro Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Name and Address of Facility
Wylie Funeral Home, P.A.
638 N. Gilmor Street; Baltimore, Maryland 21217 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Honknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ∐Yes this certificate 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

0

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year

29c. License number

058232

RA STE 3/2 SPANLES MI

29d, Date signed (Month, Day, Year)

			T = For State Registrar	State of Mic	ai y iai i			te of L		Meman	Reg.	. + 1/]	235
	[®] Physici	\ 0.00	1. Decedent's Name (First, Middle, Last							2. Date of I		Day Year		ime of Death
В	/Medic		Kilmer S.	Bortz						June 2		2007		7:10 A ^M
1	Examin	er	4a. Facility Name (If not institution, give	street and number)					Location of Dea	th		4c. County of Dea		
	- Agreement		12 Glenamoy Road 5. Social Security Number 6. Se	7 49	/le ura	ast birthday)		imoni er 1 Year	Lum If Under 24 Hrs	S O Date of F	Pieth		ltimo	
	Funeral Director		009-07-2615	M 2□F	87	Yrs.	Months		Hours Min		9 ,	1919 01	ninplace (Sountry)	State or Foreign
	and the stand		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Ins	ide City Limits
	Mary -f sho	tor	MD Baltimor	e		[imoni	um						10	Yes 2∏ No
	h the	Director	10e. Street and Number				10f. Z	ip Code			10g.	Citizen of What C	ountry?	
	th wit 23a c 1st be	al D	12 Glenamoy Rd.,	#202				2	1093		:	USA		
	er dea terms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or I rto Rican, etc.)	10-	14. Race - Am Black, Wh		an,
36	s afte	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	M Yes 2 □ N If Yes, Give	10		1 □ Yes	2€ No	Specify:			Specify:	whi	te
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show market event, the Medical Examiner must be notified at	ed k	15. Decedent's Edu	Year or Dates	41-'4	16a. Deced	dent's Us	ual Occupa	ation		166	b. Kind of Business	s/Industry	
212	hin 72 an "na Medik	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	(Give life. l	kind of w DO NOT	ork done d use retired	during most of wo)	orking	1			
2	ed wit	Som	12	4	.,	Bus	ines	s Man	ager			Pest	Cont	rol
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)							me (First, Midd		,		
<u>}</u>	should be tand Mental Is marked of	۵	Russell Bortz			1				tie Schr				
Ma	d2sthandthand 7 isn	1	19a. Informant's Name/Relationship (Ty Gloria Bortz/wife	pe. Print)			•	,				ity or Town, State, ${ m MD}$ 210		1
ပ်	Heal Heal tem 2		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer				Date	_	c. Location - City o		ate
<u>ة</u>	Pages nent of I mt: If ite		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)						, 0/.	30/07	ma		MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	1	21. Signature of Eugenic eruce Lyens		_ _ Du .	22	. Name a	and Addres	s of Facility			imonium,		
'n	Per III Per III		Michael V. Fla	gle	-	Le	emmoi	n Fun Pado	eral Hom	ne of Du . Timoni	ılar	ney Valle MD 2109	y, I1	nc.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused ne cause on each lin	the death	n. Do not ent	er the mo	de of dyin	g, such as cardia	ac or respiratory	arrest,		Appro	ximate al Between
it.	Physician		Immediate Cause (Final disease or condition	Con	010	oum			ines				Cic	t and Death
-	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):		7 -		7				
		ŗ.	Sequentially list conditions, if any, leading to immediate	Duntologo	CU	anna chi							71) yns
W	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	D.	1-	4							20	Tyrs
,	execunand in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequ	lence of):								17103
68/60,	rtificate be executed ng physician and as the burial-transit	Medical		1										
_	ertifice ing ph e as th	Med	IF FEMALE:									1		-
X P P	death cer e attendin d for use	Physician/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 ☐ Fetal	Ideath 3		pregnancy				23d. Date of de Month	elivery Day	Year
	2 0 D	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5L	Other (specify)					,	
7	8 g 2 2		Part II. Other significant conditions co	ntributing to death bu	ut not resu	ılting in the u	nderlying	cause give	en in Part I.	23e. Dio	l tobac	co use contribute	to the cau	se of death?
Hecords,	w requires been signe should be	d by	_ Ca Prosonse	,						10] Yes	2 No 3 ☐ F	robably	4 ∐Unknown
Ö		Completed	PARIENJMI	SM						24a. Wa		24b. Were a	autopsy fin	dings available
	sician: The law certificate has b irector, page 2 s	ошо		tulen	110					auʻ pei 1∐ Yes	opsy formed	d? death?		n of cause of
VItal	lan: rtifica	BeC	25. Was case referred to medical examiner?	0001771	70				26. Place of De	eath (Check onl)		INO ILLIE	3 2 11	
or <	Q 5. Z	일	1 Yes 2 No	łospital: 1 □ Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 🗅	Othe	er: 4 Nursing	Home 5 ☐ Re	sidence	e 6 □Other (Sp	ecify)	
	ding Pt .r After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day		28b. Time of Injury		28c. Injury Work		28d. Describ	e how i	injury occurred		
SIO	Attending r death. ector: After by the funer	cati	Accident investigation Suicide 6 Could not be	OO- Disease (initial			M		Yes 2 ☐ No	100/1	(0)			
UIVISION	after death Director:	Certification:	4 Homicide determined	28e. Place of inju building, etc	c. (Specify	()	eet, racio	ry, office		City or T	own, S	t and Number or F State)	turai Hout	e Number,
	urs eral		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of	of my kno	wledge, death	n occurre	d at the tin	ne, date and place	ce, and due to the	e caus	se(s) and manner a	as stated.	(-)
	To the Hosp within 24 ho To the Fund completely f	Medical	one)	and manner sta	ited.	aon anu/or m				Jurieu at the tim				
	o with	2	29b. Signature and title of certifier	m	//	1	25	9c. License				Date signed (Mor	nth, Day, Y	ear)
)	(B)		Richard	1111	no	1		NO	7132		6	128/	0 1	
	A A		30. Name and address of person who co Richard Maffezzoli	/				Ç11 + +	o 330 m	Otreon 1	νπ ′	21286		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			711001	DUIL	. 550 1	OWSUII,	4 بيد.	<u></u>		
			0.00	007		1.	8	0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Joseph Richard Brown, III U /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jul 20, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 1**∑** M 2□ F 217-40-0605 1942 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County la or 28a-f show t be notified at 28a-f show N/A Baltimore Maryland XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 21211 3838 Roland Avenue Apt 1110 USA items 23a iner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ 3[™] Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "y any injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Worker Baltimore City Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Brown Rose Fisher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ranocchia Sister 7706 Gough Street, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6/29/2007 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
APPIND TIH##20b, perFH, \$309, 7/2/07 wS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE JUNE Day Year CLARENCE F BROWN **Physician** 11:07 A M 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RAMDALLSTOWN HOSPITAL CENTER NORTHWEST If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Min Months Days Hours 1 19 M 2 F 214-03-0453 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a State 28e-f show other traumatic event, the Madical Examiner must be notified at 3altimore 1 Yes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ö 21207 or Items 23a lisda Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed by If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 loyed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: If item 27 is marked of
any injury or other traumatic ever ပ Srown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 3815 Brown arence 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 14.15 21. Signature of Funeral Service Licenses Balto. ST._ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 25RD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cleases or Lijury Due to (or as a consequence of) Examiner burial-transit Cause (Disease or Injur that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by RENAL DISEASE STAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 □ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatore and title of certifier YSICIA N 2007. 30 D 42723 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL CENTER

State Registrar

32. Registrar's Signature

HARISH.

31. Date filed (Month, Day, Year) 3 2007

AVVERAHALLI

COURT ZOAD

OLD

5401

mD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 22:50 PM **Physician** Arden 0 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Social Security Number Bayriew Medical Center Himes If Under 24 8. Date of Birth (Month, Day, Year) 7/10/1915 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours M 2□ F West Virginia 91 236-14-5375 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Baltimore Essex Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 507 Wellbrook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖎 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Equipment Serviceman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora McCollam William L. Brock ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 River Road, Delta, Pennsylvania 17314 19a. Informant's Name/Relationship (Type. Print) Lawrence Lengel (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Holly Hill Mem. Gard. 7/6/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21 Signature of Funer Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lactic Heidosis /Medical Due to (or as a consequence of) **Examiner** Lower Extremity Necrosis
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Arterial use as the burial-transi Thrombosis and attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Month in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ဥ

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: To the Funeral Director: After th completely filled in by the funeral

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number 29d. Date signed (Month, Day, Year)

RES-000

JUNE 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARSH M.D. ELISABETH

4940 EASTERN AVENUE BALTIMORE, UD 21224

State Registrar

8

Certification:

Medical

31. Date filed (Month, Day, Year) 03 Registrar's Signature

1- State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** 2007 01 3:55p. M July James /Medical Andrew 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral X**□M 2□F Director 226-36-8353 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 U.S.A. 4236 Towanda Ave Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Iffes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Bethehem Steel Steel Side 12th grade na 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown 2 should be finance and Mental F . dry.
. 1 and 2 should be
... of Health and Me... ary or other tr Gladys Cato 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4236 Towanda Ave, Baltimore, Md 21215 <u> Alice Cato-Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If I 7/9/07 Baltimore, Md 4 Donation 5 Other (Specify) Loudon Park 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21. Signature of Funeral Service Licensee 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician disease cars hronic /Medical Due to (or as a consequence of): Examiner lev tens: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No or Attending Physician: after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI, completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

A. R. Ley C. Bon (670) N. Chroles St. Boldo Md 32. Registrar's Signature 31. Date filed (Month, Day, State 3 2007 Registrar

		For	State of	Maryland / De	•		Mental Hy	giene		
*		1 - State Registrar		C	ertificate of	Death		Reg. No.	T I	0 1 0 0 0
Physicia	an	Decedent's Name (First, Midd			-		2. Date of De Month	Day	Year	3. Time of Death
/Medic	and the second	Frances 4a. Facility Name (If not institution	Allen	Crane		rey or Location of Deat	<u>June</u>	25 200 4c. County		2:40a. M
Examin	er	Genesis Heal		1501)		rna Parl		Anne		ndel
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthd		r If Under 24 Hrs	8. Date of Bir	th		ace (State or Foreign
Director		216-12-7880	1 □ M 2 X F	82 Yrs	·	Tiodis Willia		6 24		VA
and w		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town or	Location				1	0d. Inside City Limits
Maryl f sho ied a	tor	MD N	IA	Balt:	imore					X□Yes 2□No
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?
th with		1701 Eutaw P	lace Apt	428	21	217		U.	S.A.	
r dea	Funeral	11. Marital Status	Armed For	dent Ever in U.S. rces?	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - America k, White,	
s afte	by Fi	1 ☐ Never Married 2 ☐ Mar	If Yes, Giv	2 XNo	1 ☐ Yes 2 💆 No	Specify:		Specify	: B1	ack
d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		15. Decede	nt's Education	16a. De	cedent's Usual Occu	upation		16b. Kind of B	usiness/Inc	dustry
hin 72 e. an "n: Medil	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	ive kind of work done B. DO NOT use retire	e during most of wo red)	rking			
filed within Hygiene. other than '	Con	10th grade	na		Laborer			Vario		obs
be file	Be	17. Father's Name (First, Middle	, Last)				me (First, Middle,		ne)	
should be ind Mental is marked o	2	Will Crane 19a, Informant's Name/Relation	chin (Tima Print)	10h M	ailing Address (Stree		Johnson		State 7in	Codol
d 2 sl th an 17 is r traur		Russell Crit			05 Winte					
t and I Health Item 27 other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pl		Date	20c. Location		·
Pages nent of I int: If its		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from S Specify)		Crematory of ourier pr		/3/07	Balti	more	, Md
permit. Pages 1 and 2.9 Department of Health at Important: If Item 27 is any Injury or other trau		21. Signature of Funeral Service	Licensee		22. Name and Add					
		Typel	to K.S	6	1300 Wab		Balti	more,	Md 2	1215
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cant only one cause on e	aused the death. Do not	enter the mode of dy	/ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	_a. lu		ncer					months
/Medical Examiner		resulting in death)	Due to (or as a consequence of):						
	er	Sequentially list conditions, if any, leading to immediate	b	or as a consequence of):						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S							
be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):						
sate be ohysici	dical		d							
ertific ling p	Mec	IF FEMALE:	On Human aut	some of presences						
eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come pf pregnancy irth 2 Fetal death ant at time of death	3 □Ectopic pregnan 5 □ Other (specify)	су			te of delive onth	ry Day Year
the d	ıysic	1 □ Yes 2 12 N <i>o</i> 9 □ Unknown	9□Unkna		omer (specify)					
The law requires that the death certific the law requires that the death certific atte has been signed by the attending page 2 should be detached for use as	by Pr	Part II. Other significant condit	ions contributing to de	eath but not resulting in th	e underlying cause g	iven in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?
w require been sig should b							10	Yes 2 □ No	3 Prob	ably 4 □Unknown
e law re has bee	Completed						24a. Was	an 24b.	Were auto	psy findings available inpletion of cause of
The ate ha	Som							ormed?	death?	2□ No
clan: ertific	Be (25. Was case referred to medic examiner?					ath (Check only o	one)		
ding Physician: The information of the function of the function of the function, page	ို	1 Yes 2 No 27. Manner Death	Hospital: 1 ☐ !		tient 3 DOA		Home 5 ☐ Resi			y)
ding I	ion:	1 Natural 5 ☐ Pendi	/4.4	th, Day Year)	ry W	ork? ☐Yes 2☐No	28d. Describe	how injury occur	reu	
Atten deatl ector:	Certification:	3 Suicide 6 □ Could	not be 28e. Place	of injury - At home, farm			28f. Location (Street and Numb	er or Rura	I Route Number,
s after all Direction by the birth of the bi	Serti	4 ☐ Homicide determ	buildir	ng, etc. (Specify)			City or To	wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,				best of my knowledge, dasis of examination and/o						
the H hin 24 the F Tplete	Medical	one)	and manr	ner stated.		nse number	The article and article			
Verition 10	_	29b. Signature and title of certifi		1/1	13	D507	75	29d. Date signe	(Nionin,	2007
17		24 Name and address of	nuliho completed action	a of death (Item 222) (Tu	no Printh	00070	7)	0	V (// /
0		30. Name and address of person JENN 1 TENK 10 C	linger 86	01 Ve tera	ne, Print	Millers	rille,	MD	2/1	08
Sta Registr		31. Date filed (Month, Day, Year	0007 8 1	egistrar's Signature	Ball of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:30 A M Dorothy McKinney Caton June 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6536 Allview Drive Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8,1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours West Virginia 234-32-6447 1 □ M 2 X F 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 No Directo MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 6536 Allview Drive 21046 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Completed by 1 ☐ Yes X☐ No Specify. Specify: White 3X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd McKinney ပ္ Priscilla Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Marcus C. Caton, Son 6536 Allview Drive, Columbia, MD 21046 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park July 1,2007 Beckley, West Virginia 4 □ Donation 5 □ Other (Specity) 22. Name and Address of Facility Harman Funeral Service, P.A. 21. Signature of Funera Service Licensee M01113 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Unknown Posmary Adenocarcinoma GWERKY resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-trans Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the after Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a, Was an 1□ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred)CROTHY 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Tig Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30573 MD 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) hittle Patoxent Pankway Colombia MD Min Find, Mp 10 11062 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #7,8,perFH,g869, 7/5/07 TT Certificate of Death 0100 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 7:26 PM 2007 Collins Alexander Leroy /Medical 46. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 13 Altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F 75 70 Maryland 03/24/193 Director 215-28-6702 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√Yes 2□No Director Baltimore Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21206 U.S.A. Funeral 4705 Parkwood Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 1952 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1954 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Perry ပ Harry Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4705 Parkwood Avenue, Baltimore, Maryland 21206 Marsha Collins / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Ceme: 07/09/2007 Owings Mills, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hots. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Heart Immediate Cause (Final disease or condition resulting in death) IEROTIC isease Atherosc **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): じしし,ルリンピスのY Division or Vital Records, P.Ø. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

5 21

State Registrar 29b. Signature and title of ceditie

30. Name and address of person

09

31. Date filed (Month, Day, Year)

St. Agnes HospitA

who completed cause of death (Item 23a) (Type, Print)

rke

YSICIAN

D0054558

29d. Date signed (Month, Day, Year)

-	REF		Please 1	State of Ma	it in B I Tte aryland	lack Inc m 10c d Depa	delible Riffer	e Ink. fh e	Ensure A 869, 07/1 leath and I Death	II Copies 2/07dhb Wental H	gien	1 (1)	e. 7 <i>*</i>	212	95
	Physici /Medic		Decedent's Name (First, Middle, Last Joyce Arlene Calla							2. Date of D Month July	eath		ear 07	3. Time of 5:16	
	Examir Funeral Director		323-28-5285	x 7. Age	e (In yrs. la 72	as <i>t birthday)</i> Yrs.		r 1 Year		8. Date of B (Month, D	irth ay, Yea	r)	imor Birthpla Countr	ce (State o	_
	aryland show	ž	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo			erald Is	le			10	d. Inside Cit	*
	with the M 3a or 28a-f t be notifie	I Director	NC Cartere 10e. Street and Number 11008 Inlet Dr.	et		Emrol		p Code	594		10g. C	Citizen of Wha	t Countr	1 □ Yes y?	X
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Norced	12. Was Decedent It Armed Forces? 1 ☐ Yes 2 ☐ Yes, Give Year or Dates:			Vas Dece f Yes, spe	edent of H	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race -	White, et		
21215-0036	within 72 hor ene. than "natur the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	16a. Deced (Give life. L	kind of wo	ork done ise retired	during most of wor l)	king	16b.	Kind of Busin		ustry	
	ild be filed v fental Hygie rked other i ilc event, th	To Be Co	17. Father's Name (First, Middle, Last) Elmer Irey			Kegi	SCEL	au Nu	18. Mother's Nan	ne (First, Middle Parsley			iig		
, Maryland	es 1 and 2 shou of Health and M item 27 Is mai other traumat		19a. Informant's Name/Relationship (7) Rev. Michael J. Ca			270	First	St.	and Number or Ru	ooklyn,	NY	11215			
Baltimore,	nit. Pages 1 artment of Hi ortant; If iter injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Fureral Service Licens)	C	lace of Dispo emetery, cren uid Ric 22	natory or dge (Name a	other plac Ceme t nd Addre	ery 7/	Date 5/07	Pi	Location - Cit	le,	MD	_
	Physician /Medical	2 17	23a. Parri. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	gle lications that caused one cause on each lir a. Due to (or as	ne. The	Do not ent	er the mo	de of dyir	neral Homonia Rd., g, such as cardiac			ey Vali		Inc. Approximate Interval Betto Onset and E	ween
760,	Examiner and size and e purial-transit	cal Examiner	Sequentially it conditions, if any, teaching to minimum acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conse i	uence o∬:									
P.O. Box 6876	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the bunal-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic p Other (s		,			23d. Date o Month			Year
	quires that en signed by uld be deta	by	Part II. Other significant conditions co	entributing to death bu	ut not resu	ulting in the ur	nderlying	cause giv	en in Part I.			o use contribu 2 No 3 [ite to the	Ł	death? Unknown
Division or Vital Records,	i: The law re icate has bee r, page 2 sho	Completed								24a. Wa aut per 1∐ Yes	opsy formed2	prio dea	r to com th?	sy findings ipletion of c 2 ☐ No	available ause of
or Vit	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	n: To Be	27. Manner of Death	Hospital: 1 Inpatie	ry	ER/Outpatien 28b. Time of Injury		OA Oth	4 □ Nursing F	ath <i>(Check only</i> lome 5 ☐ Rea 28d. Describe	sidence		(Specify)	hosp	lle
Division	or Attending after death. Director: After in by the funer	Certification:	1. Shatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of inju	ury - At ho	me, farm, str	М	1 🗆	Yes 2 □ No	28f. Location City or To		and Number (ate)	or Rural	Route Num	nber,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical Ce		vsician: To the best of the lasts of the basis of and manner sta	f examina										3)
)	To th withir To th comp	Me	29b. Signature and title of certifier	w			1	0	6 number 58303		29d. [Date signed (I	Month, E	Day, Year)	
	10		30. Name an address of person who c	MARNES V	~	23a) (Type,	Print)	en	veirs Ct	- row	20N	N	212	O j	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 12 2	32. egistra	ar's Signa	ture	wie								

3. Time of Death

1 - For State Registrar

Physici /Medi		Michael Howar	d Cohen					:	りろろか	2	7 200	7 1559 M
Exami		4a. Facility Name (If not institution, give		wn, or Locatio				lc. County of Deat				
(pg)	4	SINAI HOSP				If Under 1 Y					N/A	
Funeral Director		5. Social Security Number 6. Se 219-42-9730 Usual Residence of Decedent	M 2□F	e (In yrs. last			ays Hours	s Min.	8. Date of Bi (Month, Di April	ay, Yea 30 ,	1945 Mar	hplace (State or Foreign ountry) cyland
land ow		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
Many a-f sh fied	햦	Maryland N/A			Balti	more						1X Yes 2 □ No
or 282	Director	10e. Street and Number				10f. Zip Co	nde			10g. 0	Citizen of What Co	ountry?
23a cust b		4100 Clarks Lane	Apt. 303				215				USA	
er dea tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💥 N	Ever in U.S.	13. V	Was Deceden f Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Spec can, Puerto F	cify Yes or Ne Rican, etc.)	0-	14. Race - Ame Black, Whit	
rs affe	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2[X] N If Yes, Give Year or Dates:	10	1	I□Yes 2🏋	No Speci	ify:			Specify: Whi	ite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	1	I 6a. Deced	lent's Usual C	occupation	anst of workin		16b.	Kind of Business/	Industry
vithin vithin han "he.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) ,		kind of work of 00 NOT use r		7001 07 17 07 1811	9		Self Empl	oved
Hygie Hygie Int, th		12 17. Father's Name (<i>First, Middle, Last</i>)			IAN A	CCOUITE		ther's Name	(First, Middle		err mibi	.oyea
lid be lental ked o	To Be	Hillard Cohen						Berth	na Gold	f		
and N and N s mar	-	19a. Informant's Name/Relationship (T	ype. Print)		19b. Mailin	g Address (S	treet and Nur	mber or Rura	Route Numl	ber, City	or Town, State, 2	Zip Code)
and 2 and 2 alth n 27 in		Jay H. Cohen, Bi	cother		6 Pro	spect	Bay Dr	ive Gr	asonv	i11∈	, Maryla	and 21638 Town, State
P = Tite		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ I	Removal from State	20b. Plac cem	e of Disponence etery, cren	sition (Name on atory or othe	of r place)	1				
t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify,		Metro	o Cre	matory	Inc.	06/28		Ba	ltimore,	Maryland
Depa Impo any ii		21. Signature of Funeral Service (Incension Thomas Gregor	7			ba rre	derick	Road	Dalt.	LIIIOT	nd, Inc. e, Maryl	and 21228
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. I	Do not ente	er the mode o	f dying, such	as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Sis								2 WEEKS
Examiner			Due to (or as a		,	CAT	HETE	2 110	FECTIV	100		2 WEEKS
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a			<u> </u>	776 (0)		160110	710		1300
xecute and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequen	nce of):							
ficate be ex physician sthe burial	E E		d									
rtificate ng phy as the	/ledi		u									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	eath 3□	Ectopic pregi Other (speci					23d. Date of del Month	livery Day Year
s that	by Ph	Part II. Other significant conditions co	ontributing to death bu	ıt not resultir	ng in the ur	nderlying caus	e given in Pa	ırt I.	23e. Did	tobacc	o use contribute to	o the cause of death?
w requires to been signer should be or		DIABETES M	ELLITUS						1 🗹	Yes	2 No 3 P	robably 4 □Unknown
law ras be	Completed	PERIPHERAL	ARTERY	DISE	ASE	_				opsy	prior to	utopsy findings available completion of cause of
i: The	Con		VASCUL	AR D	ISEA	SF			1□ Yes	ormed 2		2 1 No
Siciar siciar certif irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	-+ 0 CT ED	1/Outpetion	at 3 T DOA	Othor	ace of Death			6 □Other (Spe	
9 Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injur	ry 28	Bb. Time of		Injury at Work?				jury occurred	icity)
ending ath.	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1	/ rear/	Injury	М	1 ☐ Yes 2	□No				
safter de al Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuling, etc	iry - At home c. (Specify)	e, farm, str	eet, factory, o	ffice	2	8f. Location City or To			ural Route Number,
e Hospit 124 hour e Funer detely fill	Medical		ysician: To the best of liner: On the basis of and manner sta	examination								
To the composition of the compos	Me	29b. Signature and title of certifier		-			icense numbe				Date signed (Mont	th, Day, Year)
L		1/2	Cho Mc				D4112	9		J	INE 27	, 2007
4		30. Name and address of person who of SINAI HOSPITAL 31. Date filed (Month, Day, Year)	completed cause of de	eath (Item 23 MoNE	3a) (Type,	Print) NZY CAX	1D 51	1215				
St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatur		sels?						
DHMH 17 Bev 1/2	2001	JUL 9 3 70	OI MAKE STATE		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland		irtment of F tificate of			giene Reg. No.	1111	01017
þ	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia Medic		Marlene J. Col	·					July_	1,	2007	2:59 A™
	Examin	er	4a. Facility Name (If not institution, giv 6007 OffShore				4b. City, Town, o	r Location of Death		4c.	County of Death Howard	1
-	Funeral		5. Social Security Number 6. S		e (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th .	9. Birthr	place (State or Foreign
i.	Director			□M 21XF	73	Yrs.	Months Days	Hours Min.	Nov 1	$\frac{1}{5}$, $\frac{1}{1}$	33 Penr	nsylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation		-		1	0d. Inside City Limits
	fanyla shov ed at	or	11		Too. Only,		mbia					1 ☐ Yes ※XXNo
	the h	rect	Maryland HOWard 10e. Street and Number	•			10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	th with 23a or ist be	al D	11235 Pear Tree W	May Apt. J.	•		21	044			USA	
	r deal	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. \	Vas Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	 Race - Americ Black, White, 	
36	s afte	by Fi	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	l I	□Yes 2X No	Specify:			Specify: Bla	ack
8	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted k	15. Decedent's E	ducation		16a. Deced	lent's Usual Occup	pation		16b. Kii	nd of Business/In-	dustry
215	thin 7; e. an "n Medl	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use retired	,	king		0 (
2	ed wil ygien her th	Completed		4			Director		- /5: 4 6 6 3 4 4 5	1	y Care (Center
and	ev d d	Be	17. Father's Name (First, Middle, Last Emory Proctor)				18. Mother's Nam	ie (<i>First, Middie</i> 3e Hunte		Surname)	
Maryland 21215-0036	is 1 and 2 should be 1 of Health and Mental item 27 is marked of other traumatic eve	욘	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru			r Town, State, Zip	Code)
	1 and 2 Health a tem 27 is		Charles T. Colli	.ns, Husbai	nd	11235	Pear Tr	ee Way A	pt.J Col	lumbi	.a, MD 21	L044
ore			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	ce	metery, crer	sition (Name of natory or other pla		Date		cation - City or To	
Baltimore,	t, Pa rtmen rtant: njury	1	4 □ Donation 5 □ Other (Specia	··	Met		ematory I	i	02/07			Maryland _
Ba	permit, Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer Thomas Gregor		Hu -	_ 7	remation 199 Frede	sseffacility rick Road	Of Mary 1 Baltin	land	l, Inc. Marvlar	nd 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not ente	er the mode of dying	ng, such as cardiac	or respiratory a	rrest,	rary rar	Approximate Interval Between
1	Physician	11	Immediate Cause (Final disease or condition				er Dement					Onset and Death Yrs.
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	-					
		-e	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequ	ence of):						
	cuted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C								
Ö,	e exec ian ar urial-tı		resulting in death) Last	Due to (or as	a consequ	ence of):						
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edical		_d								
Box 6	certifi nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of delive	erv
	death e atter	icia	in the past 12 months?	1□Live birth 4□Pregnant a]Ectopic pregnanc]Other <i>(sp</i> ec <i>ify)</i>	у			Month	Day Year
0.	at the de by the a	Physician/M	9 Unknown	9∐Unknown								
S,	ires tha signed I	by	Part II. Other significant conditions	contributing to death b	ut not resul	iting in the ur	iderlying cause giv	en in Part I.	23e. Did t		se contribute to t □ No 3 □ Prot	he cause of death?
Vital Records,	w require been sign	Completed							24a. Was			ppsy findings available
Ä	he lav e has age 2	dmo							auto perfe	psy ormed2/	prior to co death?	mpletion of cause of
ta	lan: 7	Be C	25. Was case referred to medical examiner?					26. Place of Dea	1 Yes th (Check only o	2 ☑ No one)	1 Yes	2 □ No
<u>-</u>	Physician: The lar this certificate has al director, page 2	TOE	1 ☐ Yes 2 ☐ No			R/Outpatien		4 ☐ Nursing H			6 Nether (Specia	Assisted WLiving
UC C	ding P	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Wor	ryat ńk? Yes 2 ∐ No	28d. Describe	how injur	y occurred	
Division or	Attency death	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of inj			eet, factory, office	165 2 140	28f. Location (Street an	d Number or Rur	al Route Number,
	s after al Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify,) 			City or To	wn, State,)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		(Check only 2 Medical Example)	nysician: To the best miner: On the basis o	f examinati	vledge, death on and/or in	occurred at the ti	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
	o the vithin 2 o the omple	Medical	29b. Signature and title of certifier	and manner st	ated.		29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
)	FSFO		1400/1011	Man			5-	- 3486	8	07	1-02-8	2007
•	7		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	0-1 1:	- M			
	~		31. Date filed (Month, Day, Year)	L1055 Litt			: Parkway	Columbia	a, Mary	Land	21044	
	Sta	ite	, , , , , ,	22. negisti	ar a orginali	to d	00					

			Flease	Otata of Manufacial /			•	-	
			1 - For State Registrar	State of Maryland /	Certificate of			6. 111 .	21293
	_		Decedent's Name (First, Middle, L.	ast)	0 1		Reg. N Date of Death		3. Time of Death
	Physici		(STAVSO	n Boier	· Cowlin	va		22 2007	9:08AM
	/Medi Examir		4a. Eacility Name (If not institution, gi	ive street and number)	4b. City, Town, c	or Location of Death	7 7 7 7	c. County of Death	11
			Glen Burni	e Health	Ger	n Burn	10 /	thne Itr	undel
	Funeral		,	Sex 7. Age (In yrs. last b.	irthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year eb 17, 1	9. Birthplac	ce (State or Foreign
	Director		310-34-6410 Usual Residence of Decedent	69	115.	j F	eb 1/, 1	938 OH	
	yland iow		10a. State 10b. County	10c. City, To	wn or Location			10d	I. Inside City Limits
	Man B-f sh	tor	MD Anne	Arunde1					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code			itizen of What Country	17
	ath w	ia	7355 Furnace Bra	anch Road	21060			JSA	
	er de	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of F If Yes, specify Cub 	Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- an, etc.)	 14. Race - American Black, White, etc 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2₹ No If Yes, Give Year or Dates:	1 ☐ Yes 21 No	Specify:		Specify: whit	to
Š	be filed within 72 hours after death with the Maryland ttal Hygiene. od other than "naturel", or Items 23a or 28a-f show svent, the Madical Examiner must be notified at	Completed by	15. Decedent's I	Education 16a	a. Decedent's Usual Occup	pation	16b.	Kind of Business/Indus	strv
215	hin 7. 8. 8n "n	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)			unk
21	filed wi Hygien other th	Cou	12		onstruction				
n a	be fil Ital H od oth	Be	17. Father's Name (First, Middle, Las			18. Mother's Name (Fi		,	
Maryland 21215-0036	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic svent, Its M.	²	Ira Ellic Cowling 19a. Informant's Name/Relationship		h Mailine Address /Carea				- 4-1
Ma	TENE		Jolie Green/daug		b. Mailing Address (Street 10722 Grand		•		2 0 0/
ō	1 a He em		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date		Location - City or Town	ı, State
E C			1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Spec	☐ Hemoval from State	ery, crematory or other pla	(8)			
Baltimore,	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Lice Ronal S		22. Name and Addre	ess of Facility Comy Board 6	55 U Po	1+imawa C+	moot
ω_	88 = 88		James /	The state of	Baltimore,	MD 21201	V W . Da	Termore se	1661
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do y one cause on each line.	not enter the mode of dyir	ng, such as cardiac or re	spiratory arrest,	l n	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Panereation	c cancer				Inset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
		e.	Sequentially list conditions,	b. Directo (or as a consequence	of):				
	uted 3 ansit	Examiner	Sequentially list conditions, any, training to firm softan cause. Enter Underlying Cause (Disease or injury that initiated events	_					
o,	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as a consequence	of):				
3760,		cai		d					
89 >	eath certiticate attending phy i tor use as the	Med	IF FEMALE:						
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		1		23d. Date of delivery Month Da	av Year
o.	at the de by the a tached	Physician/Med	1 Yes 2 No	4 Pregnant at time of death 9 Unknown	5 Other (specify)				
Δ.	The law requires that the death certitica tie has been signed by the attending ph rage 2 should be detached for use as th		Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the c	cause of death?
Records,	quires in sign	ed by			· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes 2	2 □ No 3 □ Probabl	ly 4 Jnknown
000	aw requir as been si 2 should	plet					24a. Was an	24b. Were autopsy	findings available
	The lavate has	Completed					autopsy performed? 1 ☐ Yes 2 🗙 N	death?	letion of cause of No
Vital	ilcien: 1 certifical rector, p	Be	25. Was case referred to medical examiner?			26. Place of Death (Cl			
of \	shys this	P	1 ☐ Yes 2 🗙 No	Hospital: 1 Inpatient 2 ER/O		4 Nursing Home		6 □Other (Specify)	
no Ou	fter ne	ion	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	Time of 28c. Injury Wor	yat 28d. k? Yes 2 ∐ No	Describe how inju	iry occurred	
Division	ol or Attending atter death. I Director: After d in by the funer	fical	2 Accident investigation 3 Suicide 6 Could not determined	be 200 Bloom of Injury. At home 6			Location (Street a	nd Number or Rural R	Poute Number.
ō.		Certification;	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, Stat	e)	
	To the Hospitel or within 24 hours atternative To the Funerel Dircompletely tilled in	edical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledg iminer: On the basis of examination at and manner stated.	e, death occurred at the tir nd/or investigation, in my o	me, date and place, and pinion, death occurred a	due to the cause(s t the time, date an	s) and manner as state id place, and due to th	e cause(s)
Y	To the within 2 To the Complet	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. Da	ate signed (Month, Day	y, Year)
)			18m	_ Physician	056	,950	Ju	ne 27, 2	007
			30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) M Rayner 1	Blad Cit. A	Pacale	00 6 MMD	21122
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	hade	7440 OMOS	· Jusa ro	year very	ger 1 1 tel 6a
			1111 0 3 200	LANGUAU No Pag					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 协 Year Month Physician 1200 Margaret Elizabeth Crouse /Medical 4a. Facility Name (If not institution, give street and number) ation of Death 4c. County of Death Examiner U (m) en nyn Baltimore Washington Medical Center Ann If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 213-36-0710 06-28-1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 209 Poplar Ave 21061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2120 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**₹** No 1 ☐ Yes 2 ☑ No white Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie Floren Williams Benjamin Cephas Cochrane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 Poplar Ave.; Glen Burnie, MD 21061 Mr. Wayne J. Crouse / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 07-02-2007 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA MO1459 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque ce of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ence of) Due to (or as a cor Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner death certificate be executed 68760, Box Division or Vital Records, P.O. ō To the Hospital within 24 hours a To the Funeral L Hospital

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter

.. Pages 1 and ...
utment of Health an

Department of Important: If it any Injury or conce.

Physician

/Medical

aftending physician and for use as the burial-transit

signed by the at Id be detached for

page 2

funeral

completely

After this cellificate director,

ours after death.
neral Director; A
filled in by the fu

3 Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

3 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1 🗡 ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Assure All Copies Are Legible. Them 10c per fh 2809 / 3-07 yt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dev Year **Physician** DEVINE 8:00 AM JAMES JUNE 2007 29 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location ol Deeth 4c. County of Death Examiner 7. Age (In yrs. lest birthday) If Under 1 Year Months Days BALTIMORE FUTURE CARE RANDALLSTUWN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral №** M 2□ F 71 Director 12/11/1935 New Jersey 152-26-4148 Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at Mt. Washington 1 ☐ Yes 2 No Director Maryland Baltimore **Paltimere** 10e. Street end Number 1. Marital Status

Apt. B

1. Marital Status

Apt. B

1. Was Decedent Ever in U.S. Armed Forces?

1 Xys 2 No 1954 If Yes, Give Year or Dates: 1956 10f. Zip Code 10g. Citizen of What Country? Funeral 21209

13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) U.S.A. 14. Race - American Indian, Black, White, etc. Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black ۾ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator 9 i. Peges 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Devine Sr. Nellie Mae Geata 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Apt. B. Mt. Washington, Maryland
Date 20c. Location - City or Town, State Aletha Devine / Wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Ceme. 07/05/07 Owings Mills, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Senature of Funeral Serve Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause of each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2 PANCREATIC CANCER Examiner Due to (or as a consequence of) Physician/Medical Examiner Attending Physician: The law requiras that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TUYOS ZIN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Juniursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Director: After this d in by the funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined 4 - Homicide To the Hospital or A within 24 hours after To the Funeral Directornial places of the Funeral Directornial filled in b 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edicai (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) M.D JUNE 29 2007 D57722 2+1 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar LEONARD RICHARDSON M.D.

1111 0 3 2007

31. Date filed (Month, Day, Year)

32. Mgistrar's Signature

1838 GREENE TREE ROAD # 300

PIKESVILLE MD ZIZO8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 30, 2007 11:00 M William James /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22,1925 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Days Months Min. 1**X** M 2□ F Hours 82 484-14-5841 TA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Timonium MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 404 Kilree Road # 101 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 143-146 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jacob Dunk Bernice Neuhaus ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Kilree Road #101 Timonium, MD 21093 Jacqueline Dunk/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State July 2007 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funds Lemmon Funeral Home of Dulaney Valley, Inc. Mighael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Sertt. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of) CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SUBTOTAL COLECTOMY 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification:

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certilier chlamo

and manner stated.

29c. License number D41410

29d. Date signed (Month, Day, Year) 30 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

200 0

32. Refistrar's Signature

State Registrar

Funeral

Director

28a-f show

7 is marked other than "natural", or Items 23a or 28a-f st traumatic event, the Medical Examiner must be notified

is marked other

permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

and

physician

the

à signed b I be deta

burial-transit

the as

nse

for

page 2 should

certificate has

After this funeral

the

filled in by

completely

Medical

24 hours after death.

the Funeral

9

death certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

Hospital or Attending

the

72 hours after

Saltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12:30 PM Helen M. DuPreez 2007 24. /Medical June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6114 Bessemer Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 😿 F 61 Director 219-42-1763 5-2-1946 VA Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County a or 28a-f show be notified at 1 ☐Yes 2 ☐ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with t nent of Health and Mental Hygiene.
nnt: If then 27 is marked other than "natural", or Items 23a or 2 nry or other traumatic event, the Medical Examiner must be n. 6114 Bessemer Avenue 21224 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3☐Widowed 4☐Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pete Leonard Knight Dorothy Cheatwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Heid - Daughter 1401 Bonsal St., Baltimore, MD 21224 Department of Health important; if Item 27 any injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6-26-07 | Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Bradley-Ashton Funeral Home, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a porsequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 🗌 Natural 5 Pending investigation Injury ours fter death. neral Director A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitallowithin 24 hours of To the Funeral Discompletely filled if

State

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name any ddress of person who complet cause of death (Item 23a) (Type, Print) AMA

MD 32. Begistrar's Signature

Medical

Course

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RES- 000

4940 EASTERN AVE. BALTIMORE MD 21224

June 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Eldegard Isolede Lenz Droddy 2007 7:30a /Medical Ju1v 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Northhampton Manor Care Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 252-54-6296 75 1931 Director 0ct 25 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hijly or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Frederick MD Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2508 Coach House Way 21701 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Heinz Joseph Lenz Irena Fischer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marta Droddy (daughter-in-law) 6672 Mid Summer Night Ct., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 7-06-07 Owings Mills, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Darge Haight U P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque ce of): Examiner live Sciondario Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ope to for as a consequence of: Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1∐ Yes 2☑ No Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 2 ER/Outpatient 3 DOA 1 ☐ Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: completely filled in by the f Hospital

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

400 to laine

MD

32 degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Ave Frederick, MI

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#18, perFH, G869, 7/6/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** 7:05 AM SHIRELLE DANJELS 2007 ANIYAH 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MD BALTIMORE CITY MERCY MEDICAL BALTIMORE, CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) AD7 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Yrs Director 6-25-NA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h Counts 10d, Inside City Limits 28e-f show other treumatic avent, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a or 21133 TISA 4801 Old Court Rd. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2€ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Infant NA Infant 18. Mother's Name (First, Middle, Maiden Suname) 17. Father's Name (First, Middle, Last) Be and Mental F Tammy Daniels Hezekiah ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 4801 Old Court Rd., Baltimore, Md. Hezehiah Daniels Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Department of Important: If any injury or once. 7-3-07 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Lad an 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Extreme rematuri 2 hours 57 min disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor med? 2**D**€No 2300 1 ☐ Yes 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide within 24 hours a Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Ambiguity of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D003913

DHMH 17 Rev 1/2001

State

Registrar

30, Name and address of person who completed cause

0

3 2007

Date filed (Month, Day, Year)

Paul Place

of death (Item 23a) (Type, Print)

300

32. Registrar's Signature

07-04994 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Raymond Erwin 1- For State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 30, 2007 Year 1730 hrs Medical Examine RAYMOND T. ERWIN 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Havre De Grace Harford Harford Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign MARYLAND Months Days Hours Director 1XXM 2 F 212-28-0348 74 1932 AUG Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 X No 28a-f show HARFORD **ABERDEEN** MARYLAND with the Maryland Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21001 1565 MITCHELL LANE U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. death v Armed Forces? Never Married 2 Married 1 XX Yes BLACK Yes, Give Year 50/52 4 X Divorced 1 Yes 2 X No specify: Specify: Widowed 3 þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ges 1 and 2 should be filed within 72 P of Health and Mental Hygiene. If item 27 is marked other than "r 21215-0036 12th grade STEELWORKER BETH STEEL 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RALPH ERWIN PERNEASE GILSOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို 19a. Informant's Name/Relationship (Type, Print) B 1565 Mitchell Ln., Aberdeen Md., Claude W. Brown/Friend 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 20a, Method of Disposition Date crematory or other place) or other Pages 1 1 X Burial 2 Cremation 3 Removal from State GARRISON FOREST 07 - 10 - 07OWINGS MILLS, MD Donation 5 Other Specify 21. Signature of Funeral Service Licen 22. Name and Address of Facil WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. S PHILA BLVD, ABERDEEN, MD, 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Probable sepsis due to pneumonia, renal failure Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other Inpatient 2 V ER/Outpatient 3 DOA Nursina Home 5 Residence 6 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

Medical

241

30. Name and address of person who completed cause of death (Item 23a)

determined

(Specify)

and manner stated

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD.

MP

31. Date filed (Month, Day, Year) State 2007 Registra

29b. Signature and title of certifier

Homicide 29a. Certifier 1

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 1, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Carol Anne Farley 10:40 A.M 28 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 Wallace Avenue Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 112 22 1407 62 Director Nov. 26, 1944 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Maryland Anne Arundel Baltimore 1 ☐ Yes 2 🕱 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 29 Wallace Avenue 21225 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 11 Marital Status 1 □ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White by 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Colfege (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygient
Important: If item 27 is marked other tha
any njury or other traumatin Radiation Therapist Health Care years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Temple Cole Ruth Wvble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin Farley Jr. / Son 29 Wallace Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) State Veteran Cem. 7/2/2007 Crownsville, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. D**ther significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been significated be page 2 should be 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 1 ☐ Yes 2/2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home Addence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28d. Scribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

elano

03

2007

the e

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

s of person who completed cause of death (Item 23a) (Type,

32. Registrar's Signature

29c. License number

05

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Der State of Maryland / Der State of Maryland / Der 23a,25,27,28a-f	partment of Health and Ertificate of Death Trificate of Death	Mental Hygier)/dhb _{Reg. I}	ne Notable en en en en en en en en en en en en en
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3Time of Death
	/Medic		RONALD	FISH	JUNE 23	2007 8:55 A ^M
1	Examin	er	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL	4b. City, Town, or Location of Deat BALTIMORE	th	4c. County of Death N/A
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
40.	Director		220-36-1322 1 X 2 F 68 Yrs.	Months Days Hours Min.	06/19/1939	WASH., D.C.
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryla f sho	ō	MD N/A BALTIM	ORF		1 √ Yes 2 □ No
	h the or 28a notif	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath wit	ral	3704 NORTH CHARLES STREET UNIT #803			U.S.A.
	er de items	Funeral	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. ■ Never Married 2. Married 1. ■ Yes 2. ■ No.	 Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🌠 No Specify:		Specify: WHITE
21215-0036	72 hou natura lical E	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation	16b.	Kind of Business/Industry
2	within ene. than " he Mec	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of wo b. DO NOT use retired)	,,,,,,,	REAL ESTATE
	filed v Hygie ther t	ပ္ပ	17. Father's Name (<i>First, Middle, Last</i>)	WYER 18. Mother's Na.	me (First, Middle, Maio	
<u>a</u> n	lld be lental ked o	To Be		FISH MIKKI	I	FRIED
Maryland	2 shou and M is mai			iling Address (Street and Number or R		
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic			N. CHARLES ST. UI		LTIMORE, MD 21218
Baltimore	g = 5		20a. Method of Disposition 1	MEMORIAL PARK 06/2		DALLSTOWN, MD
Balti	permit. Pa Departmen Important: any injury once.			22. Name and Address of Facility S 8900 REISTERSTOWN		& BROS., INC. KESVILLE, MD 21208
,	19		23a. Part Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
d	Physician / /Medical		Immediate Causé (Final disease or condition resulting in death)	al injeration	99)	LINCOUA
1	Examiner		Due to 1, as a consequence of):	helvous s	ustem c	les Lendion :
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	120023	7,	75/01/01/19
4	eath certificate be executed attending physician and for use as the burial-transit	Examine	triat initialed events c.	sod latury	Metroje	kegia stillogik
60,	icate be exect physician and the burial-tra		Due to (or as a consequence of):		PAPROVED BY MEDICALE	V
98760	ficate physis the	edical	d	THEICATION	PAROVA	
Box	death certi e attending d for use a	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	NO L	23d. Date of delivery
P.O. B	00	Physician/M		Other (specify)		Month Day Year
	es that gned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ord	w require been sig should t				1 ☐ Yes	2 Probably 4 Unknown
Records,	has has	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
tal			25. Was case referred to medical	26. Place of De	1 Yes 2 A	No 1 ☐ Yes 2 ☐ No
or Vital	yslci iis cer direct	To Be	examiner? Hospital: 1 ☐ Inpatient 2 PR/Outpati	Other:	Home 5 Residence	6 □Other (Specify)
u o	ing Pt		27. Manner of Death 28a. Date of Injury 28b. Time 27. Manner of Death 28a. Date of Injury 28b. Time United	OWN Work? AA -	28d. Describe bowlin	njury occurred Subject
Division	Attending or death. ector: After by the fune	icati	a Couldent a Could not be determined 28e. lace of injury - At home, farm, a could not be determined.	1 Yes	28t Location (Street	and Number or a ural Route Number,
<u>></u>	al or A s after il Direc	Certification:	4 ☐ Homicide determined building, etc. (Specify) Roadway	street, factory, office	City or Town St Cathedral	Street Balto., MD
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, sompletely filled in by the funeral director,	edical (29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, Day, Year)
	(n)		· Gestafoldes	D00623	2816	70/25/07
	(24)		30. Name and address of person is a completed cause of dia (Item 23a) (Typer STT) A SASOWS IN THE STORY OF TH	a, Print) - Broodware	Bas tima	WE, MD 31205
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year zugene Sarr 5:00 PM JUNE 26 2007 /Medical or Location of Death

Dath Wore

I Year If Under 24 Hrs. 8. Date of Birth

Oct. 9, 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1946 West Virginia 1 MM 2 □ F 60 Director <u> 229-58-0964</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahov other than "natural", or iteme 23s or 28s-f sho vent, the Madical Examiner must be notified at 1 Yes 2 No Directo MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 103 Fourth Avenue U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give 67-68 Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Sheet Metal Industry Maintence Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ! Gilbert Garrett, Sr. Opal Wolfoud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar Important: If item 27 le any Injury or other trau QDCS. Charles Garrett, Jr. - Son 904 Powder Horn Court Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory 7-2-2007 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD epel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE **Physician** EMPHYSEMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by s been signe should be o LUNG CANCER. 1 Yes 2 No 3 Probably 4 Unknown NON-SMALL CELL 24b. Were autopsy findings available prior to completion of cause of death? EMBOLI 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural s effer de. 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALAL, 22 SOUTH GREENE STREET, BALTIMORE, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 3 2007

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Bonita McLean Gauss June 29 2007 10:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Village Road Pikesville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 M 2 F 214-12-8732 Director 86 October 13, 1920 Baltimore, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar musics notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Village Road 21208 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by If Yes, Give Year or Dates: XX Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ne any injury or other traumatic event Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administrator Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank S. Hullett Martha McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2514 Dobos Drive, Finksburg, Maryland 21048 Christopher Gauss (Son) 20c. Location - City or Town, State 21/84 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 07/03/07 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 Olhor MOO 333 23a. Pani. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Adeno Carcinoma of the 4months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a deteched f 1 ☐ Yes 2 ☐ 10 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1₽ Tes 2□ No 3 ☐ Probably 4 ☐Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Tes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2₩No Hospital: Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3□ DOA this : After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident f Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a, Certifier Medical 29b. Signature and title 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) M. Ho, M.D. 7600 SIEC I ress of person #210 Towson, (IGHAGE) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2007 0 Registrar

			For State Registrar	State of	of Maryla	and / Depa		f Health of Death		, 0		9	0.1011
	0.		Registrar Decedent's Name (First, Middle)	(ast)			incate	JI Death		2. Date of Death	g. No.		3. Time of Death
Е	Physicia /Medic	al	Ralph L. G	ordon, Jr						Month	Day	Year	C 1 11
)e	Examin		4a. Facility Name (If not institution Union Memorial					n, or Location	of Death		4c. Count	of Death	1
	Funeral		5. Social Security Number 218–32–0879	6. Sex 1XXM 2 ☐ F		rs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under	Min.	B. Date of Birth (Month, Day,		Cou	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		69	110.				May 20,	1938	Mary	rland
	yland Iow at		10a. State 10b. County		10c.	City, Town or Lo							10d. Inside City Limits
	e Mar ta-fsh tified	ctor	Maryland N/A			Baltim	ore						XXYes 2 □ No
	be filed within 72 hours after death with the Maryland the Hygliene. Indepther than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	I Director	10e. Street and Number 3939 Roland Ave	enue Apt	713		10f. Zip Co	de 2121	1	10	g. Citizen of USA		untry?
	ems 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	n U.S. 13.	L Was Decedent If Yes, specify	of Hispanic Or	rigin? (Spec	ify Yes or No- ican, etc.)		ce - Amer	rican Indian,
36	ırs after al', or ite xamine	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced		2 ☐ No ive		1 □ Yes ŽŽ				Speci		White
Maryland 21215-0036	72 hou natura iical E		15. Deceden	's Education st grade completed)	16a. Dece	dent's Usual O	ccupation one during mo:	st of working	7 1	6b. Kind of E	Business/I	ndustry
121	filed within Hygiene. wher than " ent, the Mec	Completed	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)			one during mo etired)			3 1	,	
22	e filed val Hygie other t vent, th		17. Father's Name (First, Middle,	Last)			Mechani		er's Name (First, Middle, M		comob	olle
Jan	should be fand Mental Is marked of umatic eve	To Be	Ralph L. G	*	•			Le	lia			ŕ	
ary	2 should be and Mental is marked of aumatic ev		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Si	reet and Numb	per or Rural	Route Number,	City or Town	, State, Z	lip Code)
	12 je d		Margaret Cole		1 20	1201	1 Dellw	ood Ave	enue,	Baltimo	re, Ma	ryla	nd 21211 Town, State
Baltimore,	60 O b.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		i State	cemetery, crei	matory or otne	r piace)					
altin	그두다는	i	4 □ Donation 5 □ Other (S		141	etro Cre			7/2/20		tonsvi	.ite,	Maryland
m	permi Depar Impor any ir once.		tym 19	3. Hens	20					Funeral Itimore		land	. 21211
*			23a. Part1. Enter the disease, or shock, of heart failure. List	complications that only one cause on	caused the d each line.	eath. Do not ent	er the mode o	dying, such as	s cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		DIAL	INFAR	CTION	1				2 DAYS
	Examiner				,	sequence of):	4						10 YEARS
	P #	ner	Sequentially list conditions, if any, caung to immediate cause. Enter Underlying Cause (Disease or injury	Date to	(or as a nom	sequente offi				-			
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Co	NGES	Sequence of):	HEAR	TF	AICU	RE			10 YEARS
8760,	cate be executed physician and the burial-transit	dical E			`	406EST	EROL	AEMI	A				10 VEARS
ဖ	rtificate ng phy as the	/ledic	IE EEMALE.	<u> </u>									1.
Вох	death certific e attending p ed for use as t	ian/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth 2 F	etal death 3	⊒Ectopic pregr					ate of deli onth	very Day Year
P.0.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki	Inant at time on nown	of death 5 L	Other (speci	у)					
	requires that the een signed by th hould be detache	by Pt	Part II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying caus	e given in Part	l.	23e. Did tob	acco use cor	tribute to	the cause of death?
ord	w requires that s been signed t should be det									1 1	s 2□No	3 □ Pro	obably 4 Unknown
or Vital Records,	e law has b	Completed								24a. Was ar autopsy perform	y	Were au prior to d death?	topsy findings available completion of cause of
a			25. Was case referred to medical					00. 81		1 Yes 2	No	1 ☐ Yes	2 No
Ž	Physician: r this certific ral director,	o Be	examiner?	Lloopitol	Unpatient 2	ER/Outpatier	nt 3□ DOA	Othor		<i>(Check only one</i> e 5 ☐ Reside		her /Sne/	cifu)
n or	ing Phys After this uneral dii	$\vdash i$	27. Manner of Death 1 Natural 5 Pendin	28a. Date g (Mo.	<u> </u>	28b. Time o		Injury at Work?	28	3d. Describe ho			<i></i>
Division	Attending r death. ector: After by the fune	ficat	2 Accident investig	not be 28e Plac	e of injury - A	t home, farm, str		1 ☐ Yes 2 ☐ fice				ber or Ru	ıral Route Number,
Ö	tal or rs after al Dire	Certification:	4 ☐ Homicide determ	build	ding, etc. (Sp	ес <i>пу)</i>				City or Town	, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ng Physician: To the Examiner: On the and ma									
	To th withir To th comp	Me	29b. Signature and title of certifie	7				cense number		29	d. Date sign	ed (Monti	h, Day, Year)
			Amat	M.1) .		A	12438	946	บี	"UNE	30/	2007
	0		30. Name and address of person	who completed cau	ise of death (Item 23a) (Type,	Print)	MEI	MOR,	AL il	Loc D M	-AL	MD
	Sta	te	31. Date filed (Month, Day, Year)	MOFFAT	Registrar's Si	gnature A	CAME D	1301	1 -1-11	. – (7	-3711	7 / 500	1
	Registr	ar	JUL 4	5 4001	The state of	S.J. Jan	Service of the servic						

		State of Maryl	and / Dep		lealth and	Mental Hyg	•	7 2131
Physici /Medio		1. Decedent's Name (First, Middle, Last) Elmer C. Greaver			•	June 2	5 Day 200	3. Time of Death
Examir		4a. Facility Name (If not institution, give street and number) 705 Compass Road		Middl	or Location of Deat e River	:	4c. County of Balt	
Funeral Director		212-20-2964 \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	yrs. last birthda 81 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 925 N	Birthplace (State or Foreign Country) Maryland
Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10c	. City, Town or Mi	Location ddle Riv	er			10d. Inside City Limits 1 ☐ Yes 2 🛂 No
3a or 28a st be not	I Direc	10e. Street and Number 705 Compass Road		10f. Zip Code 2122	:0	1	0g. Citizen of Wha	at Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	in U.S.	B. Was Decedent of Fif Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. Vhite
d within 72 ho giene. er than "natur the Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)	16a. Dec (Gi)ife Sch	pedent's Usual Occup ve kind of work done o DO NOT use retire DOI Bus	oation during most of wo d) Driver	rking	16b. Kind of Busir Studen	ness/Industry
uld be file Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Elmer F. Greaver			1	me (First, Middle, M e Kramm		
and 2 sho ealth and I n 27 is me ier trauma		19a. Informant's Name/Relationship (Type. Print) Lottie J. Greaver /wife	70	iling Address (Street 5 Compas		Baltimo	re MD 2	21220
Pages 1 ment of Hi ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Holly	position (Name of rematory or other pla HILL Cem	; -	5/28/07	20c. Location - Cit Baltimo	ore MD
permit, Departi Import any Inj once.		21. Signature of Express Service Licenses		22. Name and Addre	y Funer	al Home	of Ess	alto. MD sex 21221
Physician /Medical Examiner brian-fransit	cal Examiner	23a. Part 1. Enter the disease, or complications at caused the candinate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23a. Part 1. Enter the disease, or complications at cause on each line. a. Due to (or as a condition or complete the cause of the cause) Due to (or as a condition of the cause). Due to (or as a condition of the cause) Due to (or as a condition of the cause).	lval lval sequence of):	frtery l Væseul	1, conc.	l Slase		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf prediction in the year 12 months? 4 ☐ Pregnant at time year 12 months year 12 months year 13 months year 14 months ye	Fetal death 3	B⊟Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	,
quires that n signed by ild be deta	by	Part II. Other significant conditions contributing to death but not			ven in Part I.	23e. Did tob		ute to the cause of death? ☐ Probably 4 Ûnknown
: The law rec cate has bee , page 2 shot	Completed					24a. Was an autops perform	y prio ned⊋ dea	re autopsy findings available or to completion of cause of tth?]Yes 2 ☐ No
hysician his certifi I director	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No Hospital: 1 \sum Inpatient	2 ☐ ER/Outpati	ent 3 DOA Oth		ath <i>(Check only on</i> Home 5 Reside	ence 6 Other	(Specify)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation:	27. Manner of Déath 1 Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	28b. Time Injury	/ Wo	ry at rk? Yes 2 □ No	28d. Describe ho	w injury occurred	
ital or Attrassiter de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - A building, etc. (Sp.	At home, farm, s	street, factory, office		28f. Location (St. City or Town		or Rural Route Number,
he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my Medical Examiner: On the basis of examiner and manner stated.	knowledge, de mination and/or	ath occurred at the ti investigation, in my	me, date and plac opinion, death occ	e, and due to the ca urred at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
To t To 1	M	29b. Signature and title of opriffer	_a	29c. Licens	se number	25	9d. Date signed (1	Month, Day, Year) 7 7
5		30. Name and address of person who completed cause of death ((Item 23a) (Type	e, Print) DLCEARCU	ren Blva	P. Balti	moreli	11/2/12/15
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Red Tar's S	ignature	Couli	-v	, , , , , , , , , , , , , , , , , , , ,		

DHMH 17 Rev 1/2001

nysici	an	Decedent's Name (First, Middle	, Last)		00/11	ificate of	Deain	2. Date of Month	Day		3. Time of Death
Medio	cal	Betty Gregg 4a. Facility Name (If not institution	give street and n	umber)		4b. City, Town, o	or Location of Do	June	29, 2	2007 County of Dea	1235 A
kamir	ner	541 Meadowood		umberj			_	auı	46.		
neral		5. Social Security Number	6. Sex	7. Age (In yrs		Edges If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of	Birth Day, Year)	Harfor	rthplace (State or Fore ountry)
ector		219-34-2124 Usual Residence of Decedent	1 □ M 2 💢 F	68	Yrs.	WOTHIS Days	Hours M	Aug.			Maryland
1		10a. State 10b. County		10c. C	ity, Town or Loca	ıtion					10d. Inside City Lim
fled.	tor	Maryland Harf	ord		Edgewo	od					1 ☐ Yes 2 🔯
8 DO	Directo	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What C	ountry?
ledical Examiner must be notified at		541 Meadowood	Drive			210				USA	
	Funeral	11. Marital Status	Armed F		U.S. 13. Wa	as Decedent of H res, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	 Race - Am Black, Whi 	
2	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, G		1 🗆	Yes 2√2 No	Specify:			Specify: B	lack
1	ted	15. Decedent	's Education		16a. Deceder	nt's Usual Occup	pation		16b. Ki	ind of Business	
	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	(Give kir life. DO	nd of work done NOT use retired	during most of v d)	vorking			·
	ပ္ပ	12			Ho	memaker			0	wn Home	5
	Be	17. Father's Name (First, Middle, I	· -				18. Mother's N	lame (First, Mid	dle, Maiden	Sumame)	
	မ	Andrew (nmn)	Davis		10000			Mae Dor			
		19a. Informant's Name/Relationsh			11.5			Rural Route Nur			, ,
		Javon Green / Gr 20a. Method of Disposition	andson	20b.	Place of Dispositi	ion (Name of		, Edgewo Date		D 21040 ecation - City or	
		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St			cemetery, cremate			6 07			
ė		21. Signature of Funeral Service A		100	ohn Wesle	-				ngaon,	Maryland
once.		Affler	Dog of		1	McComas	Funeral	. Home,	P.A.	- Marin Gregoria Linea	1 0 000
ian ical ner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Hey	each line.	ith. Do not enter the Car	1317 COK the mode of dyir	CESBURY	Rd., Ab	arrest,	-	Approximate Interval Between
cal ner	Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition	a. Due to	pertensi	ith. Do not enter to the Caraguence of):	1317 COK the mode of dyir	CESBURY	Rd., Ab	arrest,	-	Approximate
ached for use as the buriar-transit	icai Examiner	shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequential list of clitical if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	a. Due to c. Due to d	each line. Octobro O (or as a conse	quence of): quence of): quence of):	1317 COK the mode of dyir	sesbury ng, such as card	Rd., Ab	ease.	-	Approximate Interval Between Onset and Death
cal	by Physician/Medical Examiner	shock, or heart-failure. List of the shock of heart-failure. List of disease or condition resulting in death) Security list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo	a. Due to	o (or as a consection of pregnant at time of prown	quence of): quence of): quence of): quence of):	the mode of dyir	sesbury ng, such as card sescular	Rd., Ab. iac or respiratory Cles 23e. Di	d tobacco u	23d. Date of de Month	Approximate Interval Between Onset and Death
cal	Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Sequential let conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to	o (or as a consection of pregnant at time of prown	quence of): quence of): quence of): quence of):	the mode of dyir	sesbury ng, such as card sescular	23e. Di	d tobacco u Yes 2	23d. Date of de Month se contribute t No 3 P	Approximate Interval Between Onset and Death O
er	Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Sequential let conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to c. Due to d	o (or as a consection of pregnant at time of prown	quence of): quence of): quence of): quence of):	the mode of dying white white Walker Value	ren in Part I.	23e. Di	d tobacco u Yes 2 as an topsy rformed? 2 No	23d. Date of de Month Se contribute t No 3 P 24b. Were a prior to death?	Approximate Interval Between Onset and Death O
al er	To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List Immediate Cause (Final disease or condition resulting in death) Security let or cities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions. If the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No	Due to Du	each line. Devices of or as a consection of or as a consection of pregnant at time of the common of	quence of): quence of): quence of): quence of): sulting in the under ER/Outpatient	the mode of dyir who volume to be compared to the mode of dyir who volume to be compared to be c	en in Part I. 26. Place of Der: 4 In Nursing	23e. Di 24a. W au pe eath (Check on)	d tobacco u Yes 25 as an topsy rformed? 2 No y one)	23d. Date of de Month se contribute t No 3 P 24b. Were a prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Day Year On the cause of death? The completion of cause of the cau
al er	To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to Due	each line. Devices of or as a consection of or as a consection of pregnant at time of the common of	quence of): quence of): quence of): quence of): quence of): sulting in the under	the mode of dyir	en in Part I. 26. Place of Der: 4 In Nursing	23e. Di 24a. W au peath (Check on)	d tobacco u Yes 25 as an topsy rformed? 2 No y one)	23d. Date of de Month se contribute t No 3 P 24b. Were a prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Day Year On the cause of death? The completion of cause of the cau
cy me mineral unocion, page 2, should be detached for use as me building and all of the colors of th	To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Securities list of conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Notural S Pending	Due to Du	each line. Octobro	quence of): quence of): quence of): quence of): quence of): sulting in the under ER/Outpatient 28b. Time of Injury 100 me. farm. street	the mode of dyin white white Value of the mode of dyin white Value of the mode of dyin white Value of the mode of	en in Part I. 26. Place of Der: 4 \(\text{\tint{\text{\tint{\texi}\text{\texit{\text{\texict{\texi{\text{\texicr{\texi{\texi{\texictex{\texit{\texi{\text{\texi{\texi{\texi{\texite\texi{\tex{	23e. Di 23e. Di 24a. W 24a.	d tobacco u Yes 2 as an topsy rformed? S 2 No y one) ssidence to be how injury	23d. Date of de Month se contribute to Month 24b. Were a prior to death? 1 Yes 6 Other (Spe	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? Property Day Year On the cause of death? The completion of cause of death? The completion of cause of the
Grafy midd in by the turbina director, page 2 should be detached for use as the buffat-transit	Certification: To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Security of the conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to a. Due to c. Due to d	each line. Octobro	quence of): quenc	the mode of dying cause gives the results of the re	en in Part I. 26. Place of Der: 4 Nursing yat k? Yes 2 No	23e. Di 23e. Di 24a. W 24a. W 25eath (Check on) Home 5 Re 28d. Describ	d tobacco u Yes 25 as an topsy rformed? 2 No y one) esidence (street and rown, State)	23d. Date of de Month se contribute t No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spery occurred)	Approximate Interval Between Onset and Death Death Onset and D
C 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Securitian list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No No No No 25. Was case referred to medical examiner? 1 Yes 2 No No No No No No 27. Manner of Death No No No No No No No N	a. Due to a. Due to c. Due to d	each line. Octobro	quence of): quenc	the mode of dying cause gives the results of the re	en in Part I. 26. Place of Der: 4 Nursing yal yes 2 No	23e. Di 23e. Di 24a. W 24a. W 25eath (Check on) Home 5 Re 28d. Describ	d tobacco u Yes 2 as an topsy rformed? 2 No y one) ssidence to how injury (Street and Town, State) e, date and	23d. Date of de Month se contribute t No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spery occurred)	Approximate Interval Between Onset and Death Death Onset and D
by the initial director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical Examiner	shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) Securitian list or cities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could in determine (Check only one) Medical Expressions Control of the past 1 Certifying (Check only one) Certifier Certifying (Check only one) Medical Expressions Certifier Certifying (Check only one) Medical Expressions Certifier Certifying (Check only one) Medical Expressions Certifier Certifying (Check only one) Certifier Certifying (Check only one) Certifier Certifying (Check only one) Certifier Certifying (Check only one) Certifier Certifying (Check only one) Certifier	a. Due to a. Due to c. Due to d	each line. Octobro	quence of): quenc	the mode of dyir who was a common at the tingstion, in my on 29c. License	ren in Part I. 26. Place of Der: 4 \(\text{ Nursing yat } \) Yes 2 \(\text{ No } \) No attention death oce e number	23e. Discontinuo del Control d	d tobacco u Yes 2 Bas an topsy rhormed? Sidence (s) the how injury own, State, and to the state of the sta	23d. Date of de Month Se contribute t No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spery occurred) d Number or R and number applace, and dure e signed (Month)	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** کّ 120 /Medical 4b. City, Town, or Location of Death 4c. County of De ution, give street and number) **Examiner** If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) une 26, 1922 9. Birthplace last birthday **Funeral** Months Days 1 □ M 2 □ VF Yrs. MD. 220-24-2351 85 June Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter anote. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Carrol1 X□Yes 2□No MD Sykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Schoolhouse Road 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Work Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Johsnon Lucille Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6624 Sykesville Road Sykesville, MD 21784 Mrs. Justine Reese (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem. Park Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/5/2007 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT Sykesv Name and Address of Facility AIGHT FUNERAL ykesville, MD HOME 21784 & CHAPEL, + (410)-7 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Toleredia /Medical Due to ras a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s page 2 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ∐ Yes 2∭D No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Aath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death. Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month/Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** EVELYN GAREY July 1 2007 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Aug. | 9,1928 Franklin Woods Nursing Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🛱 F Months 78 Director West Virginia <u>218 22 2054</u> Usual Residence of Decedent illed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show treumatic event, it e Madical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 124 Covered Wagon Road 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100000 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Can Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Pages 1 and 2 should be ment of Health and Mentalent: If Item 27 Is marked Arley Clay Holt Ivy Dove Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sue Crosswhite (daughter) 6641 S.E. Johnson Creek Blvd Portland OR 97206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park Jul 3,2007 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Si 22. Name and Address of Facility Bruzdzinski Funeral Home PA uneral Service License 1407 Old Eastern Avenue Essex Maryland 21221 nter the disease, or heart failure. List complications at ceused if Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm late Cause (Fi Cause (Final LEIDHYOMA **Physician** METASTATIC SARCOMA /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the buriat-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown has been signed by ge 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEPRESSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2)(No 1 Tes 1 Yes Attending Physicien; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: No. Certification; To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a, Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4000 alus اريب 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 SQUARE DR, BALTIMORE PARSHALL 9105 FRANKLIN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 03 Registrar

07-04888 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elvin Garland State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 27, 2007 Medical Examiner 1038 hrs as/apa 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 4201 Penhurst Ave. **Baltimore** 9. Birthplace (State or Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Foreign Months Director Days Hours Min 3-60-434 Country) 1×M Usual Residence of Decedent À 10c. City, Town or Location 10d. Inside City Limits marked other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at once 1 Yes 2 No altimor permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Flygiene. Чa. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country USA 420 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married Married Yes 4 Divorced f Yes, Give Yea 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 struction 17. Father's Name (First, Middle, 18.Mother's Name (First, Middle, Maiden Surname) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address mportant: If item 27 is Avenue 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) 2 Cremation Other Specify Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical UNPENDED AMENDED ending physician use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown signed by the att I be detached for Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been s if director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 ٩ 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work' Certification: 1 V Natural Yes 2 No within 24 nours
To the Funeral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 27, 2007 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Assistant Medical Examiner

Tasha Greenberg MD

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Division or Vital Records, P.O. Box 68760,	Baltir Baltir	Baltir
o the Hospital or Attending Physician: The law requires that the death certificate be executed the state of the Hospital or Attending Physician: The law requires that the death certificate be executed to the state of the state	Phy /M Exa	permit. F
o the Funeral Director: After this certificate has been signed by the attending physician and	sic ledi ami	Importan

			For State Registrar	State of Maryl		epartment of H Certificate of L			giene Reg. No.	17 1.7	1) 1 0 1 "
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Joseph Anthony G	able				June	28,	2007	3:15 A ^M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death		4c. C	County of Dea	th
	Ş >	J 36	1258 Rock Hill :			Pasad					rundel
es L	Funeral Director		219-18-68/5	2 T E	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05/04	y, Year)	9. Bir	thplace (State or Foreign ountry) MD
	aryland show d at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Location Pasadena					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he Ma 8a-f	Director	MD Anne Aru	ndel	Pasa				10- ON-	18/1 0	
	with the a or 2 be no	Ö	10e. Street and Number 1258 Rock Hill	Pond		10f. Zip Code 2112	2		-	en of What Co	
	eath	Funeral		Was Decedent Ever i	in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No		4. Race - Ame	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If lem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	in, Mexican, Puerto Specify:	Rican, etc.)		Black, Whit Specify:	white
ה ה	72 ho natur ilcal i	Completed	15. Decedent's Educa (Specify only highest grade of	ion ompleted)	16a. De	ecedent's Usual Occup	ation during most of work	ina i	16b. Kin	d of Business	/Industry
7	within in interest. than "I the Med	uple	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retired del Maker) -	9	Moad	Linaha	211.00
7	filed w Hygiei other ti		1. Tather's Name (First, Middle, Last)		МО	dei Makei	18. Mother's Name	(First Middle		tingho	Juse
	the final head of sed of sed of several	Be c	Joseph Gable				Agnes	,		ourname)	
	should I	ဥ	19a. Informant's Name/Relationship (Type	Print)	19b. M	failing Address (Street				Town, State,	Zip Code)
Z Z	nd 2 salth ar 27 is r trau		JoAnn Swift / Da	ughter	12	58 Rock H	Iill Roa	d, Pas	adei	na, MI	21122
nore,	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State		isposition (Name of crematory or other place Rosary Cei	1	Date 02/07		ation - City or	
altimo	nit. P antme ortan injur		21. Signature of Funeral Service Licensee	1	TOLY I						Home, PA
מ	permit. Departimports any inj		1/2//2-			169 Rivi					· ·
×	Physician		23a. Part1. Enter ne disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the cause on each line.		// /					Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or es a con	nsequence of)	Ofse Care Nellits	0.11	- 0-	0		
	Examiner	_	Sequentially list conditions, b.	Due to (or as a con	School of	otse lune	UND Vas	aucan	de	yeer,	
Н	ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a corr	les (welliten					
	certificate be executed riding physician and use as the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a con							
09/99	re be	edical	L d								
9	rtificat ng ph) as th	/ledi	IF FEMALE:								
Ď.	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome pf pro 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23	3d. Date of de Month	elivery Day Year
7.	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contri	buting to death but not	t resulting in th	ne underlying cause give	en in Part I.	23e. Did t	obacco us	e contribute t	o the cause of death?
ğ	quire an sig							10	Yes 2]No 3□P	robably 4 Unknown
e C	Physician: The law re this certificate has bee al director, page 2 sho	Completed						24a. Was autor perfo		prior to death?	utopsy findings available completion of cause of
	an: T tificat tor, pa	Be Co	25. Was case referred to medical		_		26. Place of Deat			1 □ Yes	s 20 No
>	Physician: this certific	To B	examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Oth	er: 4 \sum Nursing Ho	me 5 🗷 Resi	dence 6	□Other (Spe	ecify)
0 0	IIng Ph		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Tin Inju	iry Wor	yat k? Yes 2∐No	28d. Describe I	now injury	occurred	
VISION	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - A	At home, farm			28f. Location (S	Street and	l Number or Fi	Rural Route Number,
2	al or A s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Sp	pecify)			City or To	vn, State)		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	edical (death occurred at the tir or investigation, in my o					
	To th within To th comp	Me	29b. Signeture and talle of certifier	The was		29c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)
	3		30. Name and address of person who com	pleted cause of death	(item 23a) (Ty	rpe, Print)	7				1
			Christopher 31. Date filed (Month, Dal, Year)	de Bor a	Signature	08 mour	, Taen A	ed PC	isac	teua	ma 2/1d2
	Sta Registr		11. Date filed (Month, Day, Year)	A Section Sect	& She	all s					md 211d2
DHI	/H 17 Rev 1/2		JOL V D TEST		Page 1						

			State of Maryland / E State of Maryland / E Registrar	Department of Health and Certificate of Death		iene	7 0121
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Kathryn Dorothy Hamilton		07	01 2007	11:45 PM ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Deat	h
			Stella Maris	Timonium, Mary		Baltimo	
-0	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Yrs. Months Days Hours Mir	n. (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director		214-12-9243 85 Usual Residence of Decedent		11/29/1	921 Ma	ryland
	yland iow at		10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	a-f sh iffied	ż	MD Harford Bel A	4ir			1 ∐Yes 2 X No
	or 28 e not	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	23a ust b		702 E. Broadway	21014		U.S.A.	
	er de tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceded Tever in 0.3. 4 Tried Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	nite
5-0036	atural		15, Decedent's Education 16a.	Decedent's Usual Occupation		16b. Kind of Business/	
215	hin 72 In "ni Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	rorking		
213	d with	mo;		Homemaker		Own Ho	ome
nd nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, I	Maiden Surname)	
45 P.M. Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ဥ	Leonard Harrison Wolf		a Beck		
45 Mar	nd 2 sh alth and 27 Is m			. Mailing Address (Street and Number or i			
	1 and 2 Health em 27 I		20a Method of Disposition 20b, Place of	702 E. Broadway -		Maryland 20c. Location - City or	21014 Town, State
II: Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 ☐ Burial 2 XCremation 3 ☐ Removal from State	ry, crematory or other place)	/02/2007	D=1+1	Manualand
ŧ	nit. Partme		21. Signature of Funeral Service Licensee	Crematory, Inc. 07 22. Name and Address of Facility E	F Lagg	ahn Funeral	Maryiana Home PA
B	permit. Departr Importa any inji		C. D. Lasselw	11750 Belair Road			
	TEN T		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	,	iac or respiratory arr	est,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	2/1320 20/Er.	105c/51	2/20	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence	of):			
- 6	Examiner	_	Sequentially list conditions, b.	-f\.			
> 1/	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	31):			
2007	executed in and ial-transit	xan	that initiated events c	of):			
68760,	ne death certificate be executed the attending physician and hed for use as the burial-transit	edical E	C _a				
K 289	tificat ig phy as the	ledi					
JULY Box 6	th cer endir r use	an/Iv	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of del	•
	e dea he att	sici	in the past 12 months? 1	5 Other (specify)	-	Month	Day Year
P.0	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a	Physician/M	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I	23e. Did to	bacco use contribute to	the cause of death?
S,	signe	by	12 Mg and 12	The anaenymy eaces given in Fair i.			robably 4 SUnknown
TON	/ requ	etec	Films to thouse		24a. Was a		
HAMILTON Vital Records,	ne lav has ge 2	Completed			- autops	sy prior to reed? death?	utopsy findings available completion of cause of
AM	n: Ti ficate or, pa		25. Was case referred to medical	OS Place of F	1 Yes Death (Check only or		2 □ No
	/sicia s cert directe	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Ou	011		ence 6 ☐Other (Spe	cify)
RYN	g Phy er thi		27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at Work?		ow injury occurred	<i>Only</i> ,
O	ath. or: Afr	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
KATHRYN Division or	or Attending Physician: after death. Director: After this certifici	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa bullding, etc. (Specify)	rm, street, factory, office	28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
Ω	oital c urs af eral D		One Contifue of South the Physician To the book of any Innuvised	a death accurred at the time date and pl	and due to the	nounc(a) and manner a	n stated
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I	Medical	29a. Certifier (Check only one) (Check one) (Check only o				
	ro the vithin ro the comple	Me	29b. Signature appliede of certifier	29c. License number		29d. Date signed (Mont	
	0		I I Collecte Res	1/1550	54	F.2.0	7
	iN		30. Name and address of person who completed cause of death (Item 23a)			21222	
	10		, ,	TY VALLEY ROAD TIMO	ONIUM, MD	21093	
	Sta Registi		31. Date filed (Month, Day, Year) 32. degistrar's Signature	Lords			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 2007 29, 11:20 A Ella Louise Hughes June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner County Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 💢 F Yrs. 90 Maryland Director March 26,1917 216-05-3672 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 II. S. A. 3809 Proctor Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Company Insurance Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Frank Munk Louise Sommers ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3809 Proctor Lane, Baltimore, Maryland 21236 Leonard Francis Hughes (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or 07/03/2007 | Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examiner The law requires that the death certificate be execute physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl performed? 1 ☐ Yes 2 ☐ No Division or Vital l or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death. 12 Funeral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical bel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ARI

Q

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD

. Registrar's Signature

UND 29,2001

29c. License number

300 RULANCY Vally CO

29d. Date signed (Month, Day, Year)

TIMONIUM,

200

			1 - For State Registrar	State of M	arylan			nt of H <i>te of L</i>		ind Me	ntal Hy	giene Reg. No	-001	21	3 1 3	
1		is .	1. Decedent's Name (First, Middle, Last)							2	2. Date of De	eath Da	ıy Year	3. Time	of Death	
100	Physici /Medic		Anna Hartman	Ha11						J	une	27,	2007	7:4	7 A M	
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City	, Town, or	Location o	f Death		40	. County of Dea	ith		
4.5		. ·	10901 Edison Road	7.4	. //-	1 1: 1 X		omac er 1 Year	If Under 2	24 Hrs. La			ntgome			
ı	Funeral Director		5. Social Security Number 6. Sex	M 2XF	81	iast birthday) Yrs.	Months		Hours	Min.	Month, Date of Bi	ay, Year,	925 Penn	rthplace (State ountry)	-	
	177		181-26-2396 Usual Residence of Decedent		01					U	CL. I) , I	923 rein	Бутуанца		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits	
	a-f s	ctor	Maryland Montgomer					_			1 🗆 Ye	s 2 ⊠ No				
	or 28	Oire	10e. Street and Number					p Code				_	tizen of What C			
	ath w	Funeral Director	10901 Edison Road					854					ed Stat			
	er de Item	nue nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Armed Forces?			Vas Dec f Yes, sp	edent of Hi ecify Cuba	ispanic Orig n, Mexican	jin? (Spec , Puerto Ri	fy Yes or No can, etc.)	0-	14. Race - Am Black, Wh			
38	irs aft	by F	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	140		□ Yes	2 🙀 No	Specify:				Specify: W	hite		
Ö	2 hou	ted	15. Decedent's Educ	ation		16a. Deced				-6		16b. h	Kind of Busines:		-	
212	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or)	5+)	life. l	DO NOT	use retired	during most)	or working	,					
2	ygien rerth	Completed		5+		Hom	emak	er				1 -	Home			
nd	₽ E D >	Be	17. Father's Name (First, Middle, Last)									a, Maidei	n Surname)			
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other then "ratural", or items 23a or 28a-f show aumatic event, it a Madical Examinar must be publified at	2	Guy Hartman 19a. Informant's Name/Relationship (Type	na (Point)	Edna Walker 19b. Mailing Address (Street and Number or Rural Route											
	s 1 and 2 should of Health and Men item 27 is marke other traumatic						-									
a,	ss 1 and 2 of Health item 27 i	18	Robin H. Bond / Daughter 14220 Sawmill Court, Phoenix, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City of Dat									-				
ē	Pages nent of I int: If it		1 Burial 2 Demonstration 3 Removal from State 4 Donation 5 Other (Specify) Commetery, crematory or other place) June Montgomery Crematorium, Inc. 30, 2007 Bethesda, M										Marvlar	nd		
Baltimore,	permit. Pages Department of Important: If i any injury or once.	- 11	21. Signature of Funeral Service License		, 10110							_	rille, Inc			
m	Per De Co		XC To	_	M008	$96 \stackrel{100}{30}$	O W.	Mont	gomer	y Ave	e., Ro	ckv	ille, M	20850		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approxim Interval B	etween		
Pmy	nysician	8 9	Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonitis Due to (or as a consequence of):										2 day	d Death S		
	/Medical Examiner															
	Laminer	Ļ	Sequentially list conditions, b	b. Dysphagia Due to (or as a consequence of): Cerebellar Degeneration										one y	ear	
V	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											five	********	
Ĭ,	i be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last		Due to (or as a consequence of):									TIVE	years	
8760	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	L _a													
9	rtificat ng phy as th	ledi	15.55141.5													
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy										23d. Date of delivery Month Day		Vana	
	e dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐Unknown	t time of d		Other (MOITH	Day	Year	
О. О	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions con	tributing to death h	out not res	ulting in the u	derhina	Cause dive	on in Part I	<u></u>	23e Did	tobacco	use contribute	to the cause of	death?	
Division of Vital Records,	signe d be	Completed by	Congestive Heart F			aning in the di	idonying	ouuso give	JII III 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Yes 2		robably 4		
Ö	w require been signature should t	ete	Hypertension 24a. Was an								20	24b. Were autopsy findings available prior to completion of cause of				
Ä	he lav e has age 2	m d	,1								auto perf	psy ormed?	death?		cause of	
ta		BeC	25. Was case referred to medical						26 Place	of Death /	1⊠ Yes Check only) 1 Ye	s 2⊠ No		
≥	Attending Physician: It death. Sector After this certification by the funeral director.	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other								6 ☐Other (Sp.	(Specify)			
0	ng Ph ter th neral		27. Manner of Death	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of		28c. Injury Work	at			ribe how injury occurred				
S	ttendir death. ctor Al	catle	27. Manner of Death 1								s 2 No					
<u>≅</u>	il or Attending F after death. I Director! After d in by the funera	Į.											Rural Route Nu	m <i>ber</i> ,		
	Hospital of the said of the sa		29a. Certifier 1⊠ Certifying Phys	ician: To the heart	of multi-	nulodes de d		d at the s	o data acc	d place ==	d due to th		and masses	e etat-d	WIND COVER	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1☆ Certifying Phys (Check only 2 Medical Examin one)	er: On the basis of and manner st	f examina	ition and/or in	estigation	u at the tim n, in my op	oinion, deal	th occurred	at the time.	, date an	of and manner and du lid place, and du	e to the cause	(s)	
	omple omple	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Da	ate signed (Mor	nth, Day, Year)		
)			Durinta 1	M. M.	9			D318	39			Tun	e 28, 2	007		
	00		30. Name and address of person who	pleted cause of o	death (Iten	n 23a) (Type,	Print)	10 I U	J ,			Juil	∠ و∪∡	007		
	7		Christopher C. Dur				Mon	tgome	ry Av	e., R	ockvi	11e,	MD 208	50		
	Sta Registr		31. Date filed (Month, Day, Year)	32 registr	ar's Signa	iture	act.	,								

07-04690

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John F. Haupt State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1340 hrs **Medical Examiner** June 19, 2007 John F. Haupt 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2219 Madison Avenue Baltimore 5. Social Security Number unk 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Foreign Country) Months Days Hours Director MD 1 X M 2 F 49 Nov. 1, 1957 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 MD Baltimore death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2219 Madison Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Married Yes 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: white ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) unkunk Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 .. Pages 1 and 2 should be filed within tment of Health and Mental Hygiene. Tant: If item 27 is marked other than or other traumatic event, the Medic 12 none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Marcella Hess Albert S. Haupt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Marcella Kegler-Bower/sister 8500 Arry Place Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State permit. Page Department of Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signarum of Funeral Stryice Licensee nn 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuse. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Seizure disorder complicating head injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any leading cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED, PII, 27, 28a-f, the attending physician led for use as the burial X UNPENDED perME, g871, 9/10/07 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 ✔ No 3 Probably 4 Unknown chronic alcohol use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital:, Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural I Director: ed in by the Pending Yes 2X No subject fell 8/23/2006 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Jown, State) 2219 Madison Ave. Baltimore, MD (Specify) residence Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2007

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

07-04859

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

.110	Hammei		State of Maryland / Department of Health and Mental Hy I-For State Certificate of Death			
	Physicia		Redistrar 1. Decedent's Name (First, Middle,Last)	Reg. N 2. Date of Death		3. Time of Death
Med	dical Exami		Eric Nicholas Hammel	June 25, 200	7	1045 hrs
الم المواحقة	100		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Apparelia		4c. County of Deat Anne Arunde	
			Baltimore Washington Med. Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		MM/DD/YYYY) 9. Bi	
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	07/14/1	Forei	
	any	-	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County		10d. Inside City Limits	
	*	_	Maryland Anne Arundel Linthicum			1 Yes 2 X No
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 408 N. Hammonds Ferry Road 21090	10g.	Citizen of What Co.	
	leath with ritems 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		14. Race - Ame White, etc.	rican Indian, Black,
	after call, or	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify.			ite
	hours natur Exam	be	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of widering most of working life. DO NOT use retire		b. Kind of Business	/Industry
	imore, MD 21215-0036 Pages I and 2 should-be filed within 72 hours at neat of Health and Montal Hygiene. Iant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th General Contractor			struction
	15-C	ادہ	17. Father's Name (First, Middle, Last) Russell Hammel Jr. Deni	(First, Middle, Maii .se. Booke		
	212 uld-be Menta marko	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			te, Zip Code)
	MD id 2 sho lith and m 27 is aumati	П	Denise Hammel / Mother 408 N. Hammonds Ferry			, MD. 21090
	re, l s I and f Heal f item er tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City o	or Town, State
	Pages nent of ant: I		4 Donation 5 Other Specify: Cedar Hill Cemetery 6/2	9/2007	Baltimor	e, Maryland
	Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4001 Ritchie Highw	ay Balt:	imore, Ma	ryĺand 21225
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arrest,	shock, or heart	Between Onset and
2	raminer	1	Immediate Cause (Final disease or condition resulting in death) a. Anoxic encerhalorathy Due to (or as a consequence of):		Funeral Service, P.A. Baltimore, Maryland 21225 bry arrest, shock, or heart Approximate Interval	
			h Mixed drug (eccains and herein) interiestics			
		힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
1		Examine	Cisease or injury that initiated events resulting in death). Last			
J	cuted and transit	٩				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	dica	JUNPENDED AMENDED #4b,23a-b,27,28a-f, perME, g869, 7/13/07 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions AMENDED #4b,23a-b,27,28a-f, perME, g869, 7/13/07 TT 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown			
	ficate be g physical the buril	/We	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan		23d. Date of delive Month	ery Day Y ear
	x 68 h certi tendin use as	iciar	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnal			
	Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certificars after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	hys	1 Yes 2 No 9 Unknown g Unknown	OO- Did tob-		to the cause of death?
	that the ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			obably 4 Unknown
	ds, F quires en sign uld be	ted		24a. Was an		autopsy findings available
	Sorce law re has be	Completed		autopsy performe	ed? death?	
	Re(The ficate page	S	25. Was case referred to medical 26. Place of Death (Check of	1 Yes 2	/ No 1	Yes 2 No
	'ital sician: is certi	Be	examiner? Hospital: A longition 2 ER/Outhoticat 3 DOA Other; Nursing		esidence 6 Oth	ner:
	of V g Phy fter th	- T	1 ✓ Yes 2 No 27. Manner of Death 28. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred	
	on endin eath. or: A	tio	Natural 5 Pending C/10/2007 III Yes 2 y No	unk		
	ViSi or Att fiter de Direct in by	ifica	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
	Dj spital nours a neral i	Certification:	4 Homicide determined (Specify) unk	unk		
	Division To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the		29a. Certifier (Check only one) Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause(s t the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
	To t To t	Medical	and magner stated. 29b. Signature and hitle of certifier 29c. License number		29d. Date signed (A	
4			O.C.M.E.		June 27, 2007	
	1 ok)	30. Name and address of person who completed cause of death (Item 23a)			
	Hum		Susan Hogan MD. Assistant-Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regis	niej.	TIT A 9 COAL PROMPTED 19. Williams	Year) 1 3 2007 32. Registrar's Signature		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

		Amend #19a, perFH, G86 1. Decedent's Name (First, Middle, La			Oeru	neate (of Death	2. Dete of Dee		Year	3. Time of Death			
Physicia /Medica		Edna J. Hause			Month 6/27	6/27/2007		2:00pm						
Examine	_	te Fecility Neme (If not institution, giv 1602 Olive Street					4b. City, Town, or I Baltimo		4c. County of Death N/A					
Funeral Director		5. Social Security Number 6. S 212-46-3038	ex 7. Age □M 2\$2 F	(In yrs. les		If Under 1 Y Months D		8. Date of Birth (Month, Day 8/31/1	, _{Year)} 943	9. Birthplece (State or Country)				
how		Usuel Residence of Decedent 10a. State 10b. County		10d. Inside City Lim										
Ba-f s	흥	MD N/A				1 XYes 2 N								
ath with the Marylar 23s or 28s-f show Lat be notified at	5	10e. Street end Number 1602 Olive Stree	et		10f. Zip Co	21230	1	0g. Citizen of W	hat Country SA	7				
urs aftar dez bi', or items Eraminer m	by Fur	11. Merital Status 1 Never Married 2 Married 3. Sylvidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 3 1 If Yes, Give Year or Dates:			s Decedent es, specify Yes 202	of Hispenic Origin? (S Cuben, Mexican, Puert No Specity:	pecify Yes or No- o Rican, etc.)		e - American k, White, etc				
ithin 72 hours ne. nan "naturei", nedical Era	Completed	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	de completed) College (1-4or 5-	pleted) (Give kind of work done during most of working life. DO NOT use retired)							of Business/Industry			
Hygier ther th		7	0 Housekeeper							Cleaning				
2 2 2 2	To Be	17. Father's Neme (First, Middle, Last) Frank Ruthford					Unk							
nd 2 sho alth and N 27 is me r traume		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Paula Hamilton/Sanjuan/												
Peges 1 en nent of Heal int: if item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery July 3, 2007 Baltimore MD												
permit. Peg Department important: if any injury o pnce.		21. Sign ture of Functal Service Licer	²² Name and Address of Fecility Charles L. Stevens Funeral Home 1501 E. Fort Avenue, Baltimore								Inc. 4D 21230			
	\dashv	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.						. A	pproximate			
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Meta	toto		Ova	vian Ch				erval Between nset and Death			
g physician and as the bunal-transit	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	b	Due to (or es e consequence of):										
		resulting in death) Last Due to (or as a consequence of):												
death ce e attendii ed for usa	ar	d.												
at the desired to be a betached f	Physician/M	Part II. Other significant conditions o	23b. Did to		contribute to the cause of death									
as m goned bed	Completed by							24a. Was a perfor		availa	autopsy finding ible prior to letion of cause ath?			
ate he	ĕ							15Y	as XIXNu	101	′es 2√∑XNo			
certificate	Be	25. Was case referred to medical examiner?	11					ith (Check only or		100				
this eldi	n: To	1 ☐ Yes 2投入o 27. Menner of Death 1 XX Maturel 5 ☐ Pending	Hospital: 1 ☐ Inpatier 28a. Dete of Injun (Month, Day				Injury et Work?		ome \$\text{XResidence} 6 \text{Other (Specify)} \\ 28d. Describe how injury occurred					
vithin 24 hours effer death. To the Funeral Director: After completely filled in by tha funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	1	М	1 ☐ Yes 2 ☐ No	28f. Location (S City or Town		er or Rural F	oute Number,					
within 24 hours of To the Funeral completely filled		29a. Certifier Certifying Ph	ysician: To the best of	i my knowle examination	odge, death on end/or inves	ccurred et ti stigation, in	e time, date and place ny opinion, death occu	, and due to the c rred at the time, d	ause(s) and ma late end place, a	nner as stat and due to th	ed. e cause(s)			
ithin the comple		29b. Signature and title of certifier	and manner stet	ou.		29c. Li	cense number	2	29d. Date signed	d (Month, Da	y, Year)			
= 3 = 8		· / //ab					26203		3 July 2, 2007					
1.				ath (Item 2										

	For		Sta	ite of Mai	yland /					and M	lental H	ygiene	9				
	Reg	1 - State Certificate of Dea										Reg. No.					
Physicia		1. Decedent's Name (First, Middle, Last)									Month				3. Time		
/Medica	Λ+	Anthony A. Iannatuono									June				4:30	0 P M	
Examine	4a. Facil	ity Name (If not institution	, give street a	and number)		4	4b. City,	Town, or	Location of	of Death		4c	. County	of Death			
		Heart Homes							herv				В	altim			
Funeral	5. Social	Security Number	6. Sex 1 X M 2	DE .	(In yrs. last i		If Under Months	1 Year Days	If Under	Min.	8. Date of E (Month, I	Dav. Year.	01	l Cour	lace (State ntry)	_	
Director		-18-9684	'A	- 8	32	115.					Sept.	8,19	24	M	aryıa	na	
put »	10a. Sta	esidence of Decedent te 10b. County			10c. City, To	own or Loca	tion							1	0d. Inside	City Limits	
aryla shov																	
he M 18a-f otifie		71and eet and Number	<u>Baltim</u>	ore			P 10f. Zip		ille			10g Ci	tizon of	What Cour	atn/2		
with the bear	5 10e. Sin		_ 1 A		,		101. ZIP					Specify: White 16b. Kind of Business/Industry Advertising dle, Maiden Surname) Ssoggia mber, City or Town, State, Zip Code) 28, Parkville, Md. 21234 20c. Location - City or Town, State 7 Baltimore, Maryland 2k Funeral Home of Bel Air 3, Bel Air, Md. 21014					
2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	8820) Walther Bl		APT 4420 as Decedent Ev		12 18/	Dogo:	2123		gin? (Sn	oifu Von or I	No.			an Indian		
er de	=	tal Status Never Married 2 ∑ Marri	Arı	med Forces?		IS. W	es, spe	cify Cuba	n, Mexicar	ecify Yes or I Rican, etc.)	40-						
rs aft	_	Widowed 4 ☐ Divorced	lf \	ÕYes 2 □ No Yes, Give arorDates:	,	10	Yes	2█ No Specify:					Specify: White				
houn tura	8				16	l 6a. Decedei	nt's Usua	al Occupa	ccupation				and of B	susiness/In	dustry	_	
in 72 in 72 ledio	Eleme	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of life. DO NOT							luring mos)	t of work	ing	H					
with thar thar	Eleme	entary/Secondary (0-12)	_ Co	llege (1-4or 5+	'		Pres	iden	ıt				Α	dvert	ising		
Hyg hyg ent, 1		er's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Midd	lle, Maidei	n Surnaı	me)			
d be ental	n Rai	lph Ianna t uo	no						Т.:	iher	cia DeSsoggia						
mari		ormant's Name/Relations		int)	1	9b. Mailing	Address	(Street a				, State, Zip	, Zip Code)				
id 2 strain	G1o	ria Iannatuo	no (Wi	fe)		8820	Wa]	ther	: Blv	d, A	pt 442	8,Par	ckvi	11e ,	Md.	2123	
1 ar Hea tem 2		thod of Disposition			20b. Place	of Disposit	tion (Nat	ne of	1		Date						
nt of nt of t; If if	1 1	Rurial 2 Cremation	3 ☐ Remova	al from State	1	etery, crema	-			06/2	a /2007	Rol1	timore. Maryland				
it. Purtani		4 Donation 5 Nother (Specify)Entombment Gardens of Fait 21. Signature of Euneral Service Licensee 22. Name and A															
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	21. Sigi	lature di Fulleral Service															
	020 Pc	- and C	compliantion	a that caused t	ho doath D								LAI	I, Hu			
		shock, or heart failure. List only one cause on each line. Interval Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwoods Onset and Betwo											etween				
Physician	Immediate Cause (Final disease or condition resulting in death) a									27/							
/Medical Examiner		3 ··· ····,		Due to (or as a	consequenc	ce of):											
Jakob J.	Sequentially list conditions,																
ed sit	Cause.	if any, leading to immediate cause. Litter Underlying Cause, (Disease or injury															
and and II-trar	That init	lated events g in death) Last	C	Due to (or as a	consequenc	ce of):											
cate be executed physician and the burial-transit	<u>e</u>																
phys the	d								-								
ding se a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (specific										23d. Date of delivery					
atten for u	23b. W															Year	
the de) 1 l	⊒Yes 2□No ⊒Unknown		Unknown	ine or deat	, ,	other (a)	,cony/									
									en in Part I		23e. Di	I tobacco use contribute to the cause of death?					
signed to be	00	si ohere	(VI	130 in	las	de	1.0	1st			1[∃Yes 2	2 No	3 ☐ Pro	bably 4	Unknov	
requ	e le	1.11.	0	1 1	10	2-00		~ /	,								
e 2 s		Abdominal Aurtic Meurysin									24a. W	utopsy prior to completion of cause of					
The cate										1□ Ye			death? 1 ☐ Yes	2□ No			
cian	25. Was exa	s case referred to medica miner?	i	.1.				Louis		of Deat	h (Check on	ly one)		,	4683	str.	
hysi this c	-	Yes 2 No	Hospita	1 🔲 inpatien		Outpatient		<i>-</i>					Residence 6 BOther (Specify) Assistant				
ing F	27. Mar	nner of Death Natural 5 □ Pendin	I	a. Date of Injury (Month, Day	Year) 281	b. Time of Injury		28c. Injun Worl			28d. Descrit	escribe how injury occurred					
tend eath. tor: / the f	2 ati	Accident investiq Suicide 6	not ho				М		Yes 2 🗍	No							
ter d ter d irect n by]Homicide determ		 Place of injur building, etc. 	y - At home, <i>(Specify)</i>	, farm, stree	et, factor	y, office			28f. Location City or	n (Street a Town, Stai		ber or Run	al Route No	ımber,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	පී					4 1 "		-4.0					,				
Hosp 4 hou Fune Fune		check only 2 Medical	Examiner: C	To the best of In the basis of	examination											e(s)	
To the lawithin 2. To the lawing completed		ne)		nd manner stat	ed.		20	Linene	e number			204 5	ata el-	od /84e=4	Dour Vee		
0 1 with 0 0 0	29b. Si	gnature and title of certifie	1	\mathcal{A}	Ø		- 1			-					Day, Year,		
		1/1/1/	1/1	my 11) con	11	1.5	1 0	ر.		y cvi	1 2	1	~ ~ ~ /		
.0	30. Nar	ne and ddress of person	who complet	ed cause of dea	ath (Item 2)	a) (Type, P	rint)	1	1/	1.	ulis	17	Pin	Ch	1211		
18	W	11-11.	(24	(- 4)	me		101		u - C	سان مع	C Esp	41.	7	- 9	13.0	4	
	e 31. Dat	e filed (Month, Day, Year)	,	32 Registra	rs Signature		ANTO IN							2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-I per me, 868,06/29/07dhb

Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Salme A. Jarv Year JUNE 15, 2007 2:04 P. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death National Lutheran Home Rockville Montgomary If Under 1 Year If Under 24 Hrs. 8. Date of Birth March 4, 1919 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months 158-24-1745 1 M 2 X F 88 Estonia Yrs Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Rockville Maryland Montgomary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 9701 Veirs Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 ¥Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library Assistant Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jaan Alamaa Ann Selia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Veirs Drive Rockville Maryland 20850 Tom Miller/Chaplain 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/18/07 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road B Baltimore Maryland 21214 preste 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUBDURAL HENATONA Due to (or as a consequence of) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury LEXAMINER Due to for as a sonsequence of) RITEICATION PROVED BY MEDICAL that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2.00No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one) Other: 1 Yes -25 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hatural 5 Pending → □ Hatural ▼□ Accident May 2007 Unknown M 1 Yes **X** No Multiple Falls investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) ROCKVILLE, MD 9701 Veirs Drive 4 Homicide Nursing Home

P.O. Box 68760 of Vital Records, LO

Physician

/Medical

Examiner

Direct

Funeral

2

Funeral

Director

?7 is marked other then "natural", or Itema 23a or 28e-f show treumatic event, Ita Medical Exact or mailted at

Department ragger and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural any injury or other treumatic accession."

Physician

Examiner

be executed

ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit

certificate has been

this

à

filled in

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUN 2 9 2007

UATTI T. ANTHONY

/Medical

the Maryland

death v

nding Physician: After death. Director To the Hospitel or within 24 hours after d To the Funerel Direct

State Registrar

Mehr duly

D0051158

16 2007

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VEIRS DRIVE 9701 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ROCKVILLE

JUNE

MO LO850

TOBALL!

			1 - State of Mary State of Mary Registrar	•	rtment of Hi tificate of D		•	giene Reg. No. 🔎		0100;
	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	Year	3. Time of Death
a)	/Medic	al	Bernard	T	Jones-B 4b. City, Town, or	-	June	26 2	2007	4:20p. ^M
Ž	Examin	er	4a. Facility Name (If not institution, give street and number) Gilchrist Nursing Home		Baltim			40.000	nty of Death	
- Non-	Funeral			yrs. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)	9. Birth	nplace (State or Foreign
Ŀ.	Director		217-52-6835 Superior	58 Yrs.			06 30) 48		MD
	yland sow at			c. City, Town or Loc	eation					10d. Inside City Limits
	e Mar la-f sh tifled	ctor	MD NA	Baltim	ore	_				Y Yes 2 No
	vith th	Director	10e. Street and Number		10f. Zip Code	3.5		10g. Citizen	of What Cou	untry?
	leath v	Funeral	5731 Pembridge Ave 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar		Specify Yes or No		Race - Amer	ican Indian,
و	172 hours after death with the Maryland "natural", or items 23a or 28a-f show rdical Examiner must be notified at		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give		Yes, specify Cubar ☐ Yes 2 XNo	n, Mexican, Pue Specify:	rto Rican, etc.)		Black, White	
5-0036	hours ural", il Exar	d by	3 Widowed 42 Divorced Year or Dates:		ent's Usual Occupa	, ,		Spe		Black
7	_ = 8	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupa kind of work done d OO NOT use retired)	luring most of wo	orking	16b. Kind o	Business/i	ndustry
212	d within giene. er than " the Mec	m o	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na	Ins	staller			Ampo	orts	Inc.
D	be filed withir ital Hygiene. Id other than event, the M	Be	17. Father's Name (First, Middle, Last)				me (First, Middle	Maiden Surr	name)	
Maryland	2 should be and Menta is marked aumatic ev	ဦ	Henry Jones 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	g Address (Street a	Ruth N		ar City or To	un Stato 7	in Cada)
ā Z	ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		Toyone Butler-Friend		Pembrio					21215
	es 1 and 3 of Health f item 27 r other tr		20a. Method of Disposition	Ob. Place of Dispos		-	Date	20c. Location		Town, State
altimore,	Pages nent of I ant: If ite ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Men		· i	/3/2007	Rand	dalls	stown, Md
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Ligensee	SON 43	Name and Address arch F/H 300 Waba	s of Facility I West Ish Ave	, Balt	imore	, Md	21215
F	F		23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	o Lon	CAN					Onset and Death
50.00	/Medical Examiner		Due to (or as a co	onsequence of):						
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	onsequence of):						
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
60,	ficate be executed I physician and is the burial-transit	a E	resulting in death) Last Due to (or as a co	onsequence of):						
98/89	ficate physics the	edical	d							
XOX	death certi e attending ed for use a	In/M	IF FEMALE: 23c. If yes, outcome pf p 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d.	Date of deli	,
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)				Month	Day Year
<u>.</u>	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but no	ot resulting in the un	iderlying cause give	en in Part I.	23e. Did	tobacco use o	ontribute to	the cause of death?
Vital Records,	quires n sign	d by					1 🗆	Yes 21N	0 3 □ Pr	obabiy 4 □Unknown
ပ္ ပ	law rec as bee 2 shou	Completed					24a. Was		b. Were au	topsy findings available
ř	The ate h	mo.			·		eauto perfo 1⊟ Yes	ormed? 2 ☑ No	death?	completion of cause of 2 No
VII a	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner? Hospital: Hospital:		Otho		eath (Check only	one)		11
5	hys this	2	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient		4 ☐ Nursing	Home 5 ☐ Resi			city) tospice
\subseteq	nding F tth. r: After e funera	tion	1 ☑Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accident investigation		Work	? Yes 2 ☐ No				,
DIVISION	ai or Attending F s after death. i Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (5	At home, farm, stre Specify)	eet, factory, office			Street and No wn, State)	mber or Ru	ıral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 1 Medical Examiner: On the basis of examiner stated	amination and/or inv						
	To th within To th	Me	29b. Signature and title of certifier		29c. License			29d. Date si	gned (Monti	h, Day, Year)
);			M thirthy they	us	225	2005		June	27	2007
C	2 Y		30. Name and address of person who completed cause of death	7d (Type, I	DJS Print Charle	s St.	Polto	·Md	2.2	0 k
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	-0 L					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. airend item 26 per web 2869 7-3-07 yr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:30a^M 25 2007 June Johnson Irene 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore er 1 Year | If Under 24 Hrs. Sinai Hospital 6. Social Security Number 6. S 7. Age (In yrs. last birthday) 6. Sev 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min 1 ☐ M 2 🙀 F 91 219-10-9804 19 VA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits XXYes 2 No Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21207 3217 Milford Ave 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Private Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lu Ellen Meekins Tom Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21207 3217 Milford Ave, Baltimore, Md Gladys Palmer-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Randallstown, Md King Memorial Park 6/29/07 21. Si contunt of Funeral Service License 22. Name and Address of Facility
March F/H West Tahan 4300 Wabash Ave, 21215 Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) a Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Due to (or as a consequence of): No 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ns contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

I Hygiene. other than "natura ent, the Medical E

permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any Injury or other traumatic event

Director

Funeral

þ

Completed

Be

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner attending physician for use as the buria certificate After this

Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be Medical Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditi 10.5

1 Yes 2 No

29a. Certifier

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence →

28d. Describe how injury occurred

27. Many er of 1 (Month, Day Year) 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28h Time of 28c. Injury at Work? 1 Yes 2 No

Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ FR/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier

29d. Date signed (Month, Day, Year)

her (Specify)

30. Name and address of person who completed cause of death (Item 23a)(Type, Print) 6669 DR 13 QUILLS LF

31. Date filed (Month, Day, Year) State Registrar

0 3 2007

2. Registrar's Signature

1 Inpatient

28a. Date of Injury

within 24 hours after death To the Funeral Director:

2

7-04946								lnk. Ensu				ole.		
oseph Milton Jo		ON 1- For State	St	tate of Ma	aryland <i>i</i>			of Health a of Death	nd Men	tal Hygier		00	, -7 -7	100
Physicia		Registrar 1. Decedent's Nam	ne (First, Midd	lle,Last)		00.1					Reg. I		3. Time of I	Death
Medical Exami		Joseph	n Milto	n Johns	on						th Da e 29, 200	ay Year 17	0548 h	nrs
		4a. Facility Name (Sinai Hospi		on, give street	and number)			4b. City, Town, Baltimore	or Location o	of Death		4c. County of D	eath	
Funeral	П	5. Social Security		6. Sex		e (In yrs. last t	birthday)	If Under 1 Ye			ite of Birth (T _E	. Birthplace (Stat oreign	le or
Director		214-94	1 - 9876	1 X M 2	F		27 Y	rs.	ays Hours		ov. 30	1979 1	Country) MD)
any	-	Usual Residence of 10a, State	f Decedent 10b. County			10c. City, Tov	wn or Loc	ation					10d. Inside	City Limits
<u>*</u> *		MD						Ba	ltimore				1 X Yes	2 No
Maryland 28a-f show d at once.	Director	10e. Street and Nu	ımber					10f. Zip Code			10g.	Citizen of What	Country?	
ith the Maryland 23a or 28a-f sho notified at once.		516 Wi	.11ow Ave	enue					21212			US	SA	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be noiffied at once	Funeral	11. Marital Status			as Decedent			Vas Decedent of I					merican Indian, I	Black,
r death or ite	Fun	1 Never Marri		1	Yes 2	X No					610.)		n America	n
rs afte ural", min <u>er</u>	ò	3 Widowed 15. Decedent's E		vorced If Yes, (or Date	IS'	poleted) 16	a Deced	Yes 2 X ent's Usual Occup			ne Inf	Specify:		
64 3 -	Completed	Elementary/Sec			llege (1-4 or 5			most of working li					,	
0036 within 7 iene. er than	Jdu	10						cable ins	taller	-		Comcast		
5-00 lled wi Hygier I other		17. Father's Name			- 1	•	12		18.Mother	's Name (First,	Middle, Mai			
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 127 is marked other than " umaric event, the Merkel	Be	19a. Inf mant's N		Joseph C			10h Mail	ing Address (Str	and and Nor			nn Parker		
and 2 shoul ealth and N tem 27 is m traumatic	의			/ Sister		1		21 Glen Av						
		20a, Method of Dis					e of Disp	osition (Name of		Date Date			ty or Town, State	3
Baltimore, permit. Pages I an Department of Hea important: If iter				n 3 Ren	noval from Sta	10	· .	other place) n Cemetery		07/12/20	07 ,)_1	36	
Baltimo permit. Pag Department Important: injury or ot	-1	Donation 5 Signature of Fu	Other Suneral Service			Tibui		. Name and Addre				ral Home,	Maryland	
E P P E		M	-		3					Silmor St	reet; B	altimore,		21217
Physician		23a, Part I. Enter to failure List or		r complications on each line.	s that caused	the death. Do	not ente	r the mode of dyir	ig, such as c	cardiac or respir	atory arrest,	shock, or heart		nate Interval Onset and
M dical Examiner		Immediate Cause or condition result			hot Wound								D	eath
				Due to	(or as a conse	equence of):								
	je.	Sequentially list co if any, leading to in	mmediate	Due to	(or as a conse	equence of):								
.18	al Examine	(Disease or injury events resulting in	that initiated	C	(or as a conse	equence of);						· · · · · ·		
cecuted 's	Ě	events resulting th	death) Last	d										
e exec		UNPENDED)	X AME	NDED TIEN	1//8,perF	H , G869	9,7/6/07,W	S					
68760, cer ificate be ex iding physician se as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent	t pregnant in t		7	ne of pregnan			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			23d. Date of de	-	Vee
OX 68 eath cer iff	cian	past 12 month		4	Live birth Pregnant at	time of death		Fetal death Other (Specify)	BEctopi	c pregnancy		Month	Day	Year
Eox e death c th, atten	hysi	1 Yes 2	No 9 Ur	iknown 9	Unknown			Other (-///						
.O. that th eed by detach	ğ	Part II. Other sign	ificant condi	tions contrib	outing to death	n but not resul	lting in the	e underlying caus	e given in Pa	art I. 23			te to the cause o	
ords, F w requires s been sign should be	Completed		•								la. Was an	24b. We	re autopsy findin	gs available
of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should b	nple.							 			autopsy performe	d? dea		of cause of
tal Recc cian: The lav certificate ha		25. Was case refe	mad to madia	al [26 Dia	on of Dooth	(Check only on	Yes 2	No 1 ₩	Yes 2	No
Vital I ysician: his certifi director,	Be	examiner?		Hospital	1 Inpatie	nt 2 🗸 ER	R/Outpatie		Other;	Nursing Home		sidence 6	Other:	
n of V ding Phy After th funeral d	년 2	1 ✓ Yes 27. Manner of Dea	2 No	28	a. Date of Inju	ıry 28	b. Time o		njury at Work	k? 28d. D	escribe how	injury occurred		
ion tendin eath. for: A	tion	1 Natural		icing	un 29, 2007	os	530 hrs	1_	Yes 2	No Subje	ct shot			
Division tal or Attendi rs after death. al Director: /	ifica	2 Accident 3 Suicide		estigation ald not be 28	ie. Place of In	jury - At home	e, farm, st	reet, factory, office	e building, et	tc. 28f. Lo	cation (Stre	et and Number	or Rural Route N	umber, City
Divis Hospital or At 24 hours after d Funeral Direct tely filled in by	Certification:	4 V Homicide	dete	ermined (S	Specify) Loc	al Street				Cedar	dale Road	and Wabash	Ave., Baltimore	e, MD
To the Hosy within 24 ho To the Fun completely i		29a. Certifier (Check only one) 2						curred at the time, pation, in my opini						
To the vithing To the comp	Medical	29b. Signature and	11	and m	anner stated.				nse number				(Month, Day, Ye	ar)
		WI	/XX	4//	ru				C.M.E.		L	lune 29, 200		,
	-	30. Name and add	ress of person	n who complet	ed cause of d	eath (Item 23)	a)							
5	l	Susan Hog		Assistant I				enn Street, Ba	altimore, I	MD 21201				
	ate	31. Date filed (Mor	nth, Day, Year,	2007	32. Registra	r's Signature	600	(i)						
Regist	rar		1 03	2001	SERVICE OF STREET	w 8	1							

			1 = For State Registrar	State of Mary		artmen rtificate			nd M		giene Reg. No.	107	2132)
	D		Decedent's Name (First, Middle, Last,)						2. Date of Dea	ıth		3. Time of Death
	Physic /Medi		Doris C.	Jelley						Ju1v	Day	Year 2007	10:30A M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death			nty of Death	10.501
1		_	Keswick Multi Ca				timo						
	Funeral		5. Social Security Number 6. Sec	7. Age (In	yrs. last birthday) Yrs.	Months	1 Year Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		Usual Residence of Decedent	00	113.					Feb. 20	,1921	1	New York
	yland		10a. State 10b. County	100	c. City, Town or Lo	ocation						11	0d. Inside City Limits
	Mar B-1-8	tor	MD Baltim	ore	Pike	svill	۵						1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Number			10f. Zip					10g. Citizen	of What Coun	try?
	ath w	ral	7501 Park Heigh	ts Ave.			212	08			USA	1	
	ar de tama	Funeral		Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced	ent of His	spanic Origi	in? (Spec	ify Yes or No-	14. F	lace - Americ	
36	s afte		1 ☐ Never Married 2 ☐ Married 3 5 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		1□Yes 2		Specify:		, ,	Spe		SIG.
8	within 72 hours after deeth with the Maryland ene. than "natural" or lams 23e or 28e-f ahow ha McGral Examiner; ust be notilled at	Completed by	15. Decedent's Edu	Year or Dates:	16a Daga	dent's Usua	1.0	*:				Wh	ite
21215-0036	un 72 n na	plet	(Specify only highest grade	ompleted)	(Give	kind of wor DO NOT us	k done d	urina most c	of working	9	16b. Kind of	Business/Ind	lustry
213	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema	akar				0	Home	
	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)			COMCINE		18. Mother's	s Name	(First, Middle,			
<u>a</u>	should bant marked	70	George W. Leste	r				Ca	athei	ine C	onnors	1	
Maryland	2 sho and and is my		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address	(Street a			Route Number			Code)
	and eeith m 27			Daughter	25 Di	invale	Ros	ad. Ap	t. 4	60, To	wson,	MD 21	204
0	Pages 1 nent of H int: If its iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		 Place of Dispo cemetery, cren 	sition (Nam	e or		Da	te	20c. Locatio	n - City or To	wn, State
altimore,	tmen tant:		4 Donation 5 Other (Specify)	Α	rlington	Nati	ona1		7/20	/07	Arlin	cton.	V A
Bai	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itams 23a or 28a-1 show any Injury or other traumatic avent, the Medical Examiner reast be notified at QDCs.		21. Signature of Funeral Service License	M On	1/ - 22	. Name and	Address	of Facility					wn Road
	45240		200 Day Farmer	The June	13Km E	line I	une	al Ho	me	Reis	tersto	wn, MD	21136
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on	e cause on each line.	leath. Do not ento	er the mode	of dying	, such as ca	ardiac or	respiratory arri	est,		Approximate Interval Between
	Physician 1/Medical		Immediate Cause (Final disease or condition resulting in death)	ASPIRA	TION t	neum	0710	1				L	Onset and Death
	¹/Medical Examiner		Todaming in double	Due to (or as a con	sequence of):								
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	اهادساد	- 00	cide	ert				U	17 161047
,	nsit	Examiner	Cause (Disease or injury	100									
	be executed icien and burial-transit	Exa	that initiated events c.	D Em N Due to (or as a con									or tolorand
09/8	cate be executed physicien and the burial-transit	dical											
9	tificate ig physi as the	ledi											
X Q Q	death certifi e attending I id for use as	Physician/Me	Lob. Was docedon program	Bc. If yes, outcome of pre		I= .					23d. D	ate of deliver	у
	deat he att	sicia	in the past 12 menths? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ F 4 Pregnant at time of 9 Unknown		Ectopic pre Other (spe					N	onth [Day Year
7 0	et the de d by the a stached	Phy	9 Unknown										
ś	requires thet een signed b nould be deta	Ď	Part II. Other significant conditions conf	ributing to death but not	resulting in the un	iderlying car	use giver	in Part I.		23e. Did tob	acco use co	ntribute to the	cause of death?
5	w requir been si should	ted	Hypotusian						_	1 🗌 Ye	s 2 🗆 No	3 Proba	bly 4 🖾 Unknown
Hecord	12 S CA	ompleted							_	24a. Was an	n 24b	. Were autop	sy findings available pletion of cause of
_	T age	Co								perform	ned?	death?	2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	anital:			1 -		Death (Check only one	э)		
5	Phys this ral dir	۲.	1 Yes 2 No		ER/Outpatient			4 Nursi		5 Reside			
5	ding Phy h. After thi funeral c	tlon	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury		c. Injury a Work?			d. Describe ho	w injury occu	urred	
DIVISION	Attan deat ctor: y the	fica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	thome farm stro	M factory		s 2 No		Longtion /Ct			
5	after Dire	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	et, lactory,	Office		20	City or Town	, State)	nder or Hurai	Route Number,
	spits nours neral		29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge, death	occurred at	the time	date and n	place and	d due to the ca	use(s) and n	nannor ac eta	tod
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Examinations)	er: On the basis of exam and manner stated.	ination and/or invi	estigation, in	n my opir	nion, death	occurred	at the time, da	ite and place	, and due to t	he cause(s)
	To the Within To the Comp	×	29b. Signature and title of certifier			29c.	License r	number		29	d. Date sign	ed (Month, D	ay, Year)
			1952	Duljee	+ Salvic	j	2005	9056			1/2/	7	
	6		30. Name and address of person who con	pleted cause of death (I		Print)					11	-	
)			UJA 3	612 Fai	ILS R	4	Balt	M	0 21	211		
	Stat		31. Date filed (Month, Day, Year)	32 Règistrar's Sig	gnature	1				· · · · · · · · · · · · · · · · · · ·			
	Registra	1	JUL 0 3 2007	Deller.	15 Soc	The same							

DHMH 17 Rev 1/2001

			State of Maryland / Dei	partment of Health and M	•	_	51003
		•	_ FOI	ertificate of Death	Reg.	L. U U 1	6. 1.06.2
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Francis J. JACOS.			2007	8:15P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral	2	Ridgeway Manor Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Catonsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	place (State or Foreign ntry)
	Director		216-16-5255 1\(\overline{\mathbb{N}}\) \(\overline{\mathbb{N}}\) \(\o	Months Days Hours Min.	(Month, Day, Ye		yland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Many a-f sh	tor	Maryland Carroll Hampst	ead			1 ☐ Yes 2 🔀No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	s 23e	rail	4480 Woodsman Drive Unit #1131	21074		United Sta	
	fter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 □ Married 1 □ ☑ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White	
98	rel', or	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 ☑ No Specify:		Specify: W	nite
5	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or Items 23e or 28e-f show event, I're Maulcal Examiner in ust be motified at	Completed by Funeral	15. Decedent's Education 16a. Decedent's education (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki a. DO NOT use retired)	ing 16	b. Kind of Business/li	ndustry
12	within ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+)			.S. Posta	Corrigo
b	e filed Il Hygi other	Be C	12 17. Father's Name (First, Middle, Last)		(First, Middle, Mai	iden Sumame)	L BELVICE
ylar	Menta Menta Brked atic et	To E	Burkhardt Jacob	Cath	erine Kuh	1	
Maryland 21215-0036	12 should h and Men 7 Is marke traumatic			illing Address <i>(Street and Number or Rura</i> 30 Woodsman Drive #			o Code) 21074
	Health tem 27	3			_	c. Location - City or T	
9	Pages lent of nt: If i		I Burial 2 Micromation 3 Hemoval from State		/2007 Ba	ltimore, 1	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "neture!; or Items 23e or 28e-f show any injury or other traumatic event, I've Maryled Examiliant with the restified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hubbard Funeral Ho			-
	10 2 2 3		Mails T. Lavoyna	4107 Wilkens Aven	ue Balti	more, MD	21229 Approximate
Ы			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac c	or respiratory arrest		Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				years
4	Examiner						
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	xecution and al-tran	Examiner	that initiated events resulting in death) Last c				
760,	M requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE	d				
89	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Medi	IF FEMALE:				
Вох	ath ce attendi for use	ian/	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	rery Day Year
P.O.	the de	nysic	1 Uyes 2 No 9 Unknown	TEI Ottlei (Specify)			
ري ح	s that gned b	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	-		cco use contribute to	
ord	require sen si	ted	Hyperteusine Arteriosclestie Coma	esy Vilcolari 2000	1 ☐ Yes	2 No 3 Pro	bably 4 Mknown
3ec	ED ON CA	mple	Cerebron Acadas Academs		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
la	sicien: The taw certificate has b lirector, page 2 s	e Co	25. Was case referred to medical	26 Place of Death	1 ☐ Yes 2 ☐		2□ No
of Vital Records,	Physicien: r this certifica ral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			e 6 □Other (Spec	fy)
0 1	ng Ph víter th uneral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	e of 28c. Injury at Work?	28d. Describe how		
Division	Attending is death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f. Location (Stree	at and Number or Rui	ral Route Number.
<u>^</u>	al or A safter I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	street, factory, onice	City or Town, S		
	lospita hours unere		29a. Certifier (Check only (Ch				
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month	
)	T S S						
ıſ	11		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	0 . 64	1 -	u~-1
4	d		received generate HD 7310 Rifelias Hi	D19667 See Print) Shewrey * 505 Gles	e Brine, of	auland ?	1001
	Sta ** Registr		31. Date filed (Month, Day, Year) 32. Registar's Signature	Snorth!			
	3.0.		OCT A O THAT TOURS TO	No.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per th 9869 7-3-07 yt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** burd. Henry ennings 6 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1515 Ward Ct. Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 59 (Month, Day) **Funeral** 1**X** M 2□ F Months Days Hours Min. 110-50-1497 Director 48 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Ward Ct. 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married r than "natural", or the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver Various permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unkn Joanne ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Deborah Jennings 1515 Ward Ct., Baltimore, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 7-2-07 Owings Mills, 21, Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East & lady 1101 E. North Ave., Baltimore, Md. con 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Stomach cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23d. Date of delivery

signed by the a 2 Completed Be 2 Certification:

completely filled in by the funeral director,

this

After

death.

after death

within 24 hours a

To the Funeral C

To the Hospital or Attending

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

23e. Did tobacco use contribute to the cause of death?

Month Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed

21202

Approximate Interval Between Onset and Death

15 months

0100

3. Time of Death

1:41p

10d. Inside City Limits

1 Yes 2 □ No

Birthplace (State or Foreign Country)

N.Y

Year

NA

2007

USA

Black, White, etc.

Jennings

Black

26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 □Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type Print) MD Naminaton.

29

Paca St, Baltimore, MO 2120

31. Date filed (Month, Day, Year) State Registrar

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JUNE 2007 618 ne 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner Memorial 6. Sex 9. Birthplace (State or Foreign Social Security Number Funeral 1 □ M 2 🛛 F Months Hours Min. Director Taryland death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f shordical Examiner must be notified at 1 Yes 2 No Director TIMO Street and Number 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 ☐ Yes 2 ▼No Black, White, etc Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Itel ury or other traumatic event, the Medical Examiner Never Married 2☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life_DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ (First, Middle, Maiden Surname) 18. Mother's Name Be ۵ Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Balto.MD Department of Health Important: If Item 27 any injury or other to once. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Himore, NL 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Meta static Leionyo sarcoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an page 2 s has autopsy After this certificate 1□ Yes 2 X No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Injury 5 ☐ Pending investigation 1 Natural after death. 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day,

Craia

29b. Signature and title of certifier

(Check only one)

Watkins, MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

BW 974 1871

Union Memorial Hospital, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician Month Year MILDRED NG 1:57 PM JUND. 7005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner +COSPITAL RANDALLSTOWN NORTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 💢 🗆 F 75 Director 7 1932 June MD 218-28-4590 Usual Residence of Deceden 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 □Wes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21207 U.S.A. 4007_Dorchester Funeral Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ▼No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates "natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Mones. 12th grade Claim Processor Social Security Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Sarah Ruth Earl Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 4007 Dorchester Road, Baltimore, Md Lancelot Keating-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) King Memorial Park 7/6/07 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTION **Physician** TRACHEOSTOMY /Medical Due to (or as a consequence of): Examiner DISLODGED RACHEOSTOMI Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be SMALL-CELL LUNG CANCER 1 Mary 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has e 2 autops, performed? Yes 2 No autonsy page certificate or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Matural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 \(\) Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1/P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54352

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NORTHWEST

HOSPITAL SYOI OLD COURT ROAD RANDALISTOWN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nince A TODOF

2007

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend #5, perFH, C869, 7/24/07 TT Certificate of Death Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 33 A M Year **Physician** Month 2007 /Medical rirler 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Hopkins N/A Dolans . Age (In yrs. last birthday, 73 Yrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) June 14, 1934 Birthplace (State or Foreign Country) Social Security Number 2942 **Funeral** Days Min 1 □ M 2 🕅 F 219-30-2943 Director Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Howard 1 ☐ Yes 2 No Director Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 North Ridge Road 21043 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Sullivan Della White ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Elm Road Arbutus, MD. Shirley A. Kick, daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State West Arundel Crematory 7-1-07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signature of Euperal Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (1 as a consequence of): ۵ /Medical **Examiner** M DR. Brassec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ornsequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical BY MEDICAL IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) 1)XiYes 2□ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation June 16, 2007 WKNOWN 15
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 X No 2 Accident 3 ☐ Suicide tel 6 ☐ Could not be 28f. Location (Stree and Number or Rural Route Number, City or Town, State) 3014 NCRTH RIDGE 4 ☐ Homicide determined Mome ELLICOTT CITY Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, HonKin 1050m Johns 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2007 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			For State	State of	Marylar		artment of H		d Mental H	lygie	ne		
	100		1 - State Registrar			Cei	rtificate of	Death	O Date of	Reg.	No.	07	3. Time of Death
7	Physici /Medio		1. Decedent's Name (First, Middle Kenneth	e, Last)		Kille			2. Date of Month June		^{Day} 2007	Year	10:58 A M
	Examir	er	4a. Facility Name (If not institution 2125 Dundalk Av		ot 2		4b. City, Town, o Dunda 1		eath		4c. County of		re
	Funeral		5. Social Security Number		7. Age (In yrs.		If Under 1 Year Months Days		in. (Month,	Day, Ye	ear)	9. Birth	place (State or Foreign ntry)
ü	Director		214-52-8951 Usual Residence of Decedent			59 Yrs.			March	15,	1948	Mar	yland
	aryland show d at	-	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🏋No
	the M 28a-f notifie	recto	Maryland Balting 10e. Street and Number	liore	1	Dundall	10f. Zip Code			10g.	Citizen of W	hat Cou	
	ath with 23a on ust be	ral D	2125 Dundalk Ave	enue Apt 2			212	22			US	A	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Marr 3 Widowed 4 Divorced	ied 12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 🛣 No e		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🎇 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or uerto Rican, etc.)	No-		, White	
Baltimore, Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of (d)	working	161	o. Kind of Bus		ndustry
12	e filed wii al Hygien other th		12 Years 17. Father's Name (First, Middle,	(ant)		N∈	ever Work		Name (First, Mide	dio Mai	N/		
land	ould be fi Mental H arked ot atic evel	To Be	John Thomas Kill						erna Perl			"	
lary	12 should be and Mental 1 is marked or raumatic ev		19a. Informant's Name/Relations				ng Address (Street						
e, N	1 and 2 Health tem 27 I		Bobby Killen 20a. Method of Disposition	Broth			Greenleaf				virgin c. Location - 0		22657 own, State
timor	permit. Pages 1 and Department of Heal Important: if item 2 any injury or other once.		1 ☐ Bunal 2 【XCremation 4 ☐ Donation 5 ☐ Other (S	pecify)	State Ba		sition (Name of matory or other plac Crematory	- !	ine 30, 2007	Ва	ltimor	e C	ity, MD.
Bal	permi Depa Impo any ir		21. Signature of Juneral Service	Con	ulle	7 7	onneily F 110 Solle	rs Poin	it Road,	Dun	dalk,M	d.	21222
	Physician /Medical		23a. Paht1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	aused the deal ach line.		er the mode of dyir	ng, such as card	diac or respirator	y arrest,			Approximate Interval Between Onset and Death
A	Examiner	7.	Sequentially list conditions,	b	or as a conseq								
	ansit and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.		(401100 01).							
8760,	ficate be executed physician and sthe burial-transit	al Ex	resulting in death) Last	Due to (or as a conseq	quence of):							
9	tificate ig phys as the	ledical		d							T		
P.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Feta ant at time of o	aldeath 3□	∃Ectopic pregnancy ∃ Other <i>(specify)</i>	/		_	23d. Date Mon		rery Day Year
ords, P	w requires that the de been signed by the s should be detached	by	Part II. Other significant condition	-	ath but not res	sulting in the u	nderlying cause giv	en in Part I.				bute to	the cause of death? bably 4 □Unknown
Division or Vital Records,	The law rate has be page 2 sh	Completed								itopsy erformed	d? de	eath?	opsy findings available ompletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			ot 3 🗆 DOA Oth	or.	Death (Check on				
0	g Physer this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	28b. Time o	" OLI BOX	4 🗆 INUISIII			e 6 Othe		'fy)
sion	lending eath. or: Aft the fun	atio	1 ⊠Natural 5 □ Pendin 2 □ Accident investion 3 □ Suicide 6 □ Could	gation	h, Day Year)	Injury	M 1 🗆	Yes 2 □ No					
DIX	al or At s after d	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	inod Zoe. Flace	of injury - At h ng, etc. <i>(Speci</i>	ome, farm, str	eet, factory, office		28f. Locatio City or	n (Stree Town, S	et and Numbe State)	r or Rui	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical (ng Physician: To the Examiner: On the ba and mann	asis of examina								
)	To the virthing of the Comp.	Me	29b. Signature and title of certifie	Deen			29c. Licens	e number 2232		29d.	Date signed	(Month	, Day, Year)
	6		30. Name and address of person Scott A. Feesor	who completed caus	e of death (Iter	m 23a) (Type,	Print)	Himos	o MA	2,	1277		
	Sta		31. Date filed (Month, Day, Year)	2007 Res	egistrar's Signa	ature	- 1 · C P4	11100	,	/	2		
DH	Registi	-	JUL 03	2007	use to	X April	the same						

			Please	Type or Pri								.egible.	
	4	For _ State		State of M	1arylan		rtment of <i>tificate o</i>			-	_	0001	0100
		Registrar 1. Decedent's Nam	ne (First Middle, La	ast)		Cer	lineate of	Deal	u i	2. Date of De	Reg. No.		3. Time of Death
Physicia	ın	SARALE	,	101/			KRESHT	001		Month June	28.	2007	10:40 A M
/Medic Examin				ve street and number	r)		4b. City, Town		on of Death			County of Death	100 10 11
a		Greate	r Baltimo	re Medica	1 Cen	ter		Tows					imore
Funeral		5. Social Security N		Sex 7. A 1 ☐ M 2 ☐ F		last birthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birthp Cour	
Director	-	220-38 Usual Residence o	-65/3	X	66	113.				06/05/	1941		MD
/land ow at	ŀ	10a. State	10b. County		10c, City	y, Town or Loc						1	Od. Inside City Limits
a-f sh	ctor	MD	BALTIM	ORE		OWINGS	MILLS						1 □ Yes 2 No
or 28	Dire	10e. Street and Nu					10f. Zip Code				10g. Citiz	en of What Coul	-
s 23a nust k	Funeral Director		SSOCIATE	D WAY #307		S 13 V	211		Orlain? (Sn	pocify Ves or N	n 1	U.S.A.	
item item iner n	'n.	 Marital Status Never Mar 	ried 2 Married	Armed Forces	s?		Vas Decedento f Yes, specify C			Rican, etc.)		Black, White,	
urs af	þ	3 💢 Widowed		1 ☐ Yes 2 If Yes, Give Year or Dates	6:	1	I∐Yes 2MIN	o Spec	cify:			Specify:	MULLE
72 ho natur tical i	Completed	(Spe	15. Decedent's E	ducation ade completed)		(Give i	lent's Usual Occ kind of work dor	ne during r	most of work	king	16b. Kin	nd of Business/In	dustry
vithin ne.	mpf	Elementary/Sec		College (1-4o	r 5+)	CLE	OO NOT use reti 'DV	red)			DED	ARTMENT	STUDE
filed w Hygie ther t int, th	S		(First, Middle, Las	t)		CLL		18. M	other's Nam	e (First, Middle			310KL
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	ANTHON	,	,	KORF	PISZ 🥤		DO	ROTHY			OBECK	
shoul ind M s marl umati	F)	19a. Informant's N	lame/Relationship	(Type. Print)		19b. Mailin	g Address (Stre	et and Nu	ımber or Ru	ral Route Numi	ber, City or	Town, State, Zip	Code)
and 2 alth a 127 is er tra		DENNIFER	DANSICKE	R / DAUGH	TER	8 IND	IAN PON	Y COL	URT -	OWINGS		S, MD 21	
of He fitem		20a. Method of Dis		Removal from Sta		cemetery, cren	sition (Name of natory or other p	lace)		Date		cation - City or To	
Pag ment ant: I		4 ☐ Donation	5 ☐ Other (Spec	ify)	BALT	TIMORE				/2007		TERSTOWN A BROS.	
ermit Depart Mpor Iny in		21. Signature of	uneral Service Lice	ensee H	,		. Name and Add						, MD 21208
HU = 60		23a Part1 Enter	the disease or cou	mplications that caus	ed the deat								Approximate
	5	shock, or he Immediate Cause	art failure. List onl	y one cause on each	line.		1.						Interval Between Onset and Death
Physician /Medical		disease or conditi resulting in death)	on	Due to (or a	as a conseq	uence ():	RATORI	7 8	actu	Ju		reinen	
Examiner				b	1	letas	tatic	Pi	el Ma	mary	Ca	winter	
D #	ner	Sequentially list of it any, leading to cause. Enter Und Cause (Disease o	ongitions, minimulate lerlying		98-0 CUT-SHA	weres of):		4.0	1.				
executed n and ial-transil	Examiner	Cause (Disease o that initiated even resulting in death)	ts	C	as a conseq	wence of):	N CA	force	(100	MA			
be ex ician burial		,		Due to to	as a conseq	querice ory.							
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edica			d									
n certifi nding use a	n/M	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcor			75-4				2	23d. Date of deliv	rery
death e atte	icia	in the past 1: 1 ☐ Yes 2	2 months?	1□Live birth 4□Pregnani 9□Unknowr	t at time of o		Ectopic pregna Other (specify					Month	Day Year
w requires that the deben signed by the should be detached	Physician/M	9 ☐ Unknow	-							on- Did	<u> </u>		the cause of death?
res th iigned be de	by	Part II. Other sign	or of the	contributing to death	n but not res	sulting in the ui	nderlying cause	given in P	'ап I.				bably 4 Unknown
requi	Completed	1/	202	OPERC									
ie law has t je 2 s	Mp/	- HY	peril	seacty, a							s an opsy formed?	prior to co	opsy findings available ompletion of cause of
		25. Was case refe	epla	T				26 5	Place of Dog	1□ Yes tth (Check only		1 □ Yes	2 No
Physician: r this certificanal director,	o Be	examiner?	No	Hospital: 1 Inpa	atient 2 □	ER/Outpatier	nt 3 DOA					6 □Other (Spec	ifv)
g Phy er this eral c	n: To	27. Manner of Dea	ath	28a. Date of I		28b. Time of		njury at Vork?		28d. Describe			.,,
ath. ath. r: Aft	Certification:	Natural 2 ☐ Accident	5 ☐ Pending Investigati	on	Day reary	jury		Yes	2∐No				
r Atte ter de irecte i by tl	tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	20e. Flace of	injury - At h . etc. <i>(Speci</i>		reet, factory, offi	ce			(Street an own, State		ral Route Number,
oital c urs af eral D		00-0-15	M o	Physician: To the be	at of mu kn	owlodgo dogt	b occurred at th	o timo da	to and place	and due to th	0 031150(5)	and manner as	stated
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check anly one)	2 Medical Ex	aminer: On the basi and manner	s of examin	ation and/or in	vestigation, in r	ny opinion	n, death occi	rred at the time	e, date and	d place, and due	to the cause(s)
o the	Mec	29b. Signature an	nd title of certifier	Gra manion			29c. Lic	ense numi	ber		29d. Dat	te signed (Month	, Day, Year)
⊢≯⊢ō		> W	lax	>, 1	MD		DY	086	67		6/3	29107	
1		30. Name and add		o completed cause of		m 23a) (Type,	Print)						2(208
0		MIGUEL	-SADOV		18:		SEN TI	EEE	Rd.	. PIKE	SVIL	ue Mo	2(200
Sta Registr		31. Date filed (Mo	onth, Day, Year)	61.	istrar's Sign	ature	acti I						

/erne	etta Louder		State of Maryland 1- For State Registrar	d / Department of Certificate of	Health and Mental Hy Death	/giene Reg. No	200	7 2133
Madi	Physici cal Exami	an/	1. Decedent's Name (First, Middle,Last)			Date of Death Month Day		3. Time of Death 0444 hrs
(Cai Exami		4a. Facility Name (if not institution, give street and number	er) 4	b. City, Town, or Location of Death		4c. County of Death	
1	, 		9109 Liberty Road 5. Social Security Number 6. Sex 7. /	Age (In yrs. last birthday)	Randallstown ' If Under 1 Year If Under 24Hrs.		Baltimore Cou	
	Funeral Director		2 8 - 86 - 4932 1 M 2 F Usual Residence of Decedent	39 Yrs.	Months Days Hours Min.	┥ `	Foreig	
	v any		10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
9	faryland 28a-f show I at once	tor	10e. Street and Number	Randa	1Stown	100.0	itizen of What Cour	1 Yes 2 No
2	s with the Maryland ms 23a or 28a-f sho be notified at once	Director	9109 Liberty Roa	0	21133		ILLEGIT OF WHAT COUR	iu y :
2	h with tems 23g	Funeral	11. Marital Status 2. Was Decede		s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
	ter deat ", or ite er must	Fun	3 Widowed 4 Divorced If Yes, Give Year	2 No	Yes 2 No specify:	. 110211, 0101,	Specify: B	ack.
	nours af natural xamin	ed by	15. Decedent's Education (Specify only highest grade of	ompleted) 16a. Decedent	's Usual Occupation (Give kind of vost of working life. DO NOT use reti		. Kind of Business/l	ndustry
ć	36 nin 72 h e than "r dical E	Completed by	Elementary/Secondary (0-12) College (1-4 o	or 5+)	omemaker	-	Daire	te.
1	3, MID 21215-UU36 and 2 should be filed within 72 hours after death with the Maryland teath and Mornal Hygiene tem 27 is marked other than "natural", or items 23a or 28a-fake traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)			(First, Middle, Maide	n Surname)	· · ·
3	U Z1Z1 should be fil and Mental I 7 is marked	To Be	19a. Informant's Name/Relationship (Type, Print)	X TON	Address (Street and Number or F	Rural Route Number.	OU do City or Town, State	Zip Code)
Š	MU d 2 shou tth and n 27 is n			MOHAT) 501	E. Preston	St. Ra	110. M	02/202
			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	State crematory or oth		1.1.	. Location - City or	Town, State
ζ:			4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	. 22 N	ame and Address of Facility	207	20140.	MI)
` (Balt permit Depart Import Injury		Lowy .) with fr. 1100°	1 1 1/19	me and Address of Facility ONDASSION 1-120 S ST	cker ST.		D 21223
	Physician /Medical		23a. Part I Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death. Do not enter th	e mode of dying, such as cardiac o	r respiratory arrest, s	hock, or heart	Approximate Interval Between Onset and Death
	taminer		Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensi</u> Due to (or as a column of the co	ve cardiovascula	ar disease			Death
		-E	Sequentially list conditions, if any, leading to immediate b Due to (or as a condition)	nsequence of):				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
	cuted ind transit	I Ex	events resulting in death) Last Due to (or as a cold dd.	isequence or).				
	5 U, te be executed sysician and burial - transit	Medical	X UNPENDED AMENDED 7,1	erME,g870, 8/2/0	07 TT			
1	BOX 68 (6U, e death certificate be the attending physic ed for use as the burn	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome in the limit in the past 12 months?	come of pregnancy	tal death 3 Ectopic pregna		3d. Date of delivery Month E	/ Day Year
	50X 68/6 death certificate te attending phy I for use as the	Physician/N	1 Yes 2 No 9 ✓ Unknown g Unknown	at time of death 5 Oth	ner (Specify)			
			Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.		o use contribute to	
	UNISION OF VITAL RECORDS, P.O. Ital or Attending Physician: The law requires that the rate death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ted by		 		1 Yes 2		bably 4 Unknown topsy findings available
	COFC : law rea : has bea e 2 shou	Completed		· · · · · · · · · · · · · · · · · · ·		autopsy performed	prior to death?	completion of cause of
	tal Ke cian: The certificate ector, page	O Co	25. Was case referred to medical		26.Place of Death (Check	only one)	No 1 ✓ Ye	es 2 No
	DIVISION OF VITAL REC ours after death. The I ours after death. After this certificate I filled in by the funeral director, page	To Be	Tiv res 2 INO	atient 2 ER/Outpatient			dence 6 🗸 Other	: Scene
	on of nding Pl th. r: After e funera	ion:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of I (Month, Da	njury 28b. Time of Ir y,Year)	njury 28c. Injury at Work?	28d. Describe how is	njury occurred	
	IVISIOF or Attend after death Director: d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street or Town, State)	t and Number or Ru	ral Route Number, City
i	D Spital hours a meral I		4 Homicide determined (Specify)					
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/or investigati	red at the time, date and place, and ion, in my opinion, death occurred a	due to the cause(s) at the time, date and p	and manner as state place, and due to th	ed. e cause(s)
	F is F 8	Me	29b. Signature and title of certifier		29c. License number	- I	d. Date signed (Mo	nth, Day, Year)
			laid Hal	Van	O.C.M.E.	Ju	ine 28, 2007	
			30. Name and address of person who completed cause of Carol Allan, MD Assistant Medical Ex		Street, Baltimore, MD 2120	1		
	S Regis	tate	31. Date filed (Month, Day, Year) 32. Figis	trar's Signature	ente			
	regis	गरा	JUL V U ZVUI JOE		-			

			1 - For State Registrar	State of Man		artment rtificate			nd Men	ntal Hygier Reg.	600		21335
	Physic	ian	1. Decedent's Name (First, Middle, Las) [Date of Death Month)av V	ear	3. Time of Death
	/Medi		Herman C	·	173				1	uns, 2	8,200	7	3:15P M
)	Exami	ner	4a. Facility Name (If not institution, give	street and number)	0	4b. City,	Town, or l	ocation of I	Death J		4c. County of	Death	
			1006 Edgerly Rd.			Glen		nie		A	nne Ar	unde1	
	Funeral	Н	5. Social Security Number 6. Se	×	n yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. [Date of Birth Month, Day, Yea	ar) 9	. Birthplac	e (State or Foreign
	Director		Usual Residence of Decedent		82 Yrs.				Ma	Month, Day, Yearch 28,	1925	Mary1	and
	and		10a. State 10b. County	10	Dc. City, Town or Lo	ocation						10d	Inside City Limits
	ath with the Marylar 123a or 28e-f ehow wat be notified at	ō	Maryland Anne Arun	del (Glen Burn	ie						133.	1 ☐ Yes 2 ☑ No
	280-	Director	10e. Street and Number			10f. Zip	Code			100	Citizen of 14/h.	at Country	-
	with se or		1006 Edgerly Rd.								Citizen of Wha		
	leath	Funerai	11. Marital Status	12. Was Decedent Eve	rin II S 13		060	nanio Origin	n2 (Canada		ited S		
"	riter of		1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No	10.0.	Was Decede If Yes, speci	fy Cuban,	, Mexican, F	Puerto Rica	in, etc.)	14. Race - Black,	White, etc.	
33	urs aft	þ	3 ☑ Widowed 4 □ Divorced	If Vac Give	WII	1 ☐ Yes 2	. No	Specify:			Specify:	Whit	Δ.
ğ	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or terna 23a or 28e-f ehow int. the Medical Examinar must be notified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual	Occupati	ion		16b.	Kind of Busin		
7	hin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of worl DO NOT use	k done du e retired)	ring most o	of working				,
21	d with giene.	P O	12	College (1-401 3+)	Forma	n				Ma	nufact	uring	
b	m - 0 =	Be	17. Father's Name (First, Middle, Last)				1	8. Mother's	s Name <i>(Fir</i>	st, Middle, Maid	en Sumame)		
<u>a</u>	should by	ToE	Herman Martin Litz					Rose	Knor1	ien			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Depermit of Heelih and Menta Importent: If Item 27 is marked ery injury or other traumatic as <u>once</u> .	ľ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address	(Street an	d Number o	or Rurai Ro	ute Number, City	or Town, Sta	ate, Zip Co	de)
Σ	and and a sellth		Michael A. Litz /	Son	8 Gr	eenwoo	od Av	re., G	Glen B	Burnie,	Mary1a	nd 21	061
ore.	of He		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Nam	e of her place)	Tee	Date	20c.	Location - Cit	y or Town,	State
Ĕ	Pag nent ant: i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Elen Have			104	ıly 3, 2007		en Buri	nie.	Maryland
att	permit. Depertrimports Imports eny inju		21. Sign rure promeral Service Licens				The state of the last of the l		E	al Home			<i>j</i>
Ω	89 E 2 8		M ORN		4	irkies 21 Cra	y-Kud ain H	wv	S.E.	Glen B	, P.A. urnie.	MD 2	1061
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ne cause on each line.	onsequence of):	. 1		1		spiratory arrest,		Int	proximate erval Between set and Death
8760,	icate be executed physicien and s the burial-transit	dical Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):								
). Box 6	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Med	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pred Other (spec					23d. Dale o Month	f delivery Day	y Year
P.O.	at th d by I etach	Phy	9 Unknown										
Division of Vital Records,	w requires that some a signed a should be de	ted by	Part II. Other significant conditions con Commany Gytery	MSease.	ot resulting in the ur	nderlying cau	use given	in Part I.		23e. Did tobacco			ause of death? 4 □Unknown
ec	law asb	P.							_ :	24a. Was an autopsy	24b. Wer	e autopsy	findings available stion of cause of
=	The pag	Ö							1	performed? □ Yes 2 🗹 N	deal	th? Yes 2□	
ij	Physicien: The lav this certificete has al director, page 2	Be	25. Was case referred to medical examiner?				2	6. Place of		eck only one)			
<u></u>	hysi this o	2	1 1 1 1 1 1 2 2 3 1 NO	ospital: 1 Inpatient	2 ER/Outpatient	t 3□ DOA	Other:	4 🗆 Nursin	ng Home	5 🗷 Residence	6 □Other (Specify)	
ב	Ing P	e e	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28	c. Injury a Work?	t	28d. I	Describe how in	ury occurred		
<u>s</u>	tend eath tor: / the fi	cati	2 ☐ Accident investigation			М		s 2 □No					
<u>N</u>	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certifice completely filled in by the funeral director; p	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)					ocation (Street a City or Town, Sta	te)		
	the Hosi nin 24 ho the Fune upletely fi	Medical	ope) 2 Medical Examil	ician: To the best of maner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at estigation, in	t the time, n my opin	date and pl ion, death o	place, and di occurred at	lue to the cause(the time, date a	s) and manne nd place, and	er as stated due to the	I. cause(s)
	Vit Con To	2	29b. Signature and title of certifier	1.6		29c.	License n	umber		29d. D	ate signed (M	fonth, Day,	Year)
,	1		The state of the s	year Voctor		1)	451	48		\u	N, 20	1, 20	47
, 1	, ,		30. Name and address of person who co	mpleted cause of death	1 8/)		11.	1.4	2110	,	
			MERREDO OSURNO	2 too Mour	Han Koc	0	USU(X	34191	Man	pland	2112		
9	Sta Registra	.0	31. Date filed (Month, Day, Year)	32. Magislrar's 5	Signature	2000				1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month ^{Day} 2007 **Physician** June 30, Ida Rebecca Largent 1:10 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Lighthouse Assisted Living Essex Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 90 215-16-4576 14,1917 Maryland Director Jan. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Baltimore Director Middle River the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with 13208 Patuxent Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 100 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify. Specify: White Completed by 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) i and Mental Hyglene. is marked other than 12 Accounting Clerk Aero-Space 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matthew Ellis Martin, Sr. Lula Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Grandpermit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traumonce. Lisa Marie Rapanotti Daughter) 13208 Patuxent Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State July 2,2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Hicensee 22. Name and Address of Eacility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ate Cause (Final dise se or condition resulting in death) sement 19 Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician aftending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No icate has been siç r, page 2 should b 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 ☐ Yes 2 ☐ Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5 State 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

within 24 the

1124 Mage

29c. License number

DW6 1907

29d. Date signed (Month, Day, Year)

Avenue, Bultimore MD 2/221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** bby Lyne Lowman 1010 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City 5 Social Security Number Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 234-42-7700 Hours 1 M 2 F 1-21-1928 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 1 Yes 2 No Baltimore Funeral Director Mary land 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be. 23a 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2DNO ò 1 ☐ Yes Completed by 3 Widowed 4 □ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ortant: If item 27 Is marked other than "natu injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas 7 homas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Boltinore, MD 2/215 homas Lowman Department of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/6/07 1 Burial 2 □ Cremation 3 □ Removal from State Erest Vet. Con 1/6/01/ Dwings Mills, MD 22. Name and Address of Facility (Hatman - Flarts Funda Her 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Heisterstown Yams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) stage 4 adenocarcinoma **Physician** Pulmonary mo /Medical Due to (or as a co equence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏t Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy autopsy performed? ∕es 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

Ochby Lyne

Baltimore, Maryland 21215-003

[Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Vana Paus, MD

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANA - VALERIA PAUN, MD Sinay Hospital of 32. Rehistrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LAGUE RRE Physician 0110 M 2005 Z /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Howard <u> Hospital</u> <u>Columbia</u> If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠**M 2□F Yrs. 219-17-1128 52 4, 1954 Haití Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number with 7641 A Stony Creek Lane 21043 Haiti Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married or l Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: ≥ 3 ☐ Widowed 4 Divorced Black "natural", Completed r than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 Is marked other than ' r traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Warehouse Employee Giant Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucilia Alexis Napoleon LaGuerre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. 7641 A Stony Creek Lane Ellicott City, MD 21043 of Health Carlo LaGuerre (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 7-9-0 Metro Crematory 4 □ Donation 5 □ Other (Specify) Catonsville, Maryland 21. Signature of Funeral Service 22 Name and Address of Facility Homes, Inc. MOISSO Y 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): EPATOCELLULAR CARCINOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. After 1

within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

1 Natural

5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

Year)

2007

3 0

28a. Date of Injury (Month, Day Year)

and manner stated.

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed can

ENT PRWY

COLUMBIA, MDZICH

State Registrar

Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MUTDISON 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 64 217-40-8012 08 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Randallstown Baltimore 1 ∐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be in 21133 U.S.A. 9 Sheraton Road death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 27 Married ive No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Quality Inspector 2th grade Pages 1 and 2 should be filed vent of Health and Mental Hygicint: If item 27 is marked other it 7. Father's Name (*First, Middle, Las* 18. Mother's Name (First, Middle, Maiden Surname) Madison Lockett Madison Ellen Younger 10a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Sheraton Road, Randallstown, Md 21133 Viginia Elizabeth Madison 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 7/3/07 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service. 21215 14300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit be executed Due to (or as a consequence of): Box 68760. aftending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 🔽 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an berform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide l or A To the Funeral within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Me 26,2007 who completed cause of death (Item 23a) (Type, Print)
N 5401 01 d CT pd Randall Fowm State Registrar

Amend #12, per Inf. (869, 7/9/07 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per many 2868,06/29/07dhb Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Edith Freida Mattheiss May 31 2007 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center
5. Social Security Number | 6. Sex | 7. Age (In vrs. last birth Towson If Under 1 Year Baltimore 8. Date of Birth (Month, Day, Year) September 9 1913 Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1□M 2□F Hours Min Baltimore, Maryland 93 220 46 5612 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County death with the Marylan 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 → No Director Baltimore County Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2907 C Conroy Court USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Men al Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced other than "nature vent, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Ň/A Housewife Housekeeping Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Bender Maida Mielke 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce J Mattheiss 2755 Greene Lane Baldwin, Maryland 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. June 4 2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Perforated COLON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence offs Examiner ON APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed Fibrilla twit AtriM attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Left Physician/Medical Femur IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊡ Ko 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation I ☐ Natural Injury Subject fell 1 ☐ Yes 2 TNo 5:00 \mathbf{p}_{M} 2 X Accident 05/02/07 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City of Town, State) 10 50 50 50 608 4 Homicide Independent Living Facility Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0057740 June, 2, 2007 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Kalvin

8501

Wiley

31. Date filed (Month Pay, Year) 2007

Walle

32 Registrar's Signature

102

TOLLSON

21286

Rd

07-04992

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles Murel 2001 2121 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 30, 2007 1544 hrs Medical Examiner Charles Muriel 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 800 Blk. N. Fulton Ave 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Hours Months Days Country) Director 215-69-6459 1 X M 2 F 3 March 22 2004 Usual Residence of Deceden 10d. Inside City Limits I0c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. **Baltimore** death with the Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1917 W. Lanvale Street 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Yes 2 X No African American Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced int of Health and Mental Hygiene.

It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should'be filed within 72 hours tent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 21215-0036 n/a 0 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tarche R. DeShields

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Muriel, Jr. 19a. Informant's Name/Relationship (Type, Print) Itimore, MD Teresa Eades / Grandmother 1917 W. Lanvale Street; Baltimore, MD 21217 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State artment or aportant: If King Memorial Park 07/06/2007 Randallstown. Maryland Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 23a. Part I. Enter the disease, a complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only the cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial LINPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ⋧ Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of nas performed? death? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 Yes No 28a. Date of Injury (Month Day Year Jun 30, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Pedestrian struck by auto 1536 hrs Yes 2 V No Natural Director: d in by the f Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 800 Blk. N. Fulton Ave, Baltimore, MD 3 Suicide (Specify) Sidewalk determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 1, 2007 O.C.M.E. erson who completed cause of death (Item 23a) 30. Name and address of Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

31. Date filed (Month, Day, Year)

me

32. Registrar's Signature

2007 3

				se Type or Prir State of Ma	nt in Black Ir aryland / Dep					•	
			1 - For State Registrar			rtificate of		,	Reg. No.	2007	2 3 5
	Physici /Medio		1. Decedent's Name (First, Middle, Renate Ani	_				2. Date of De Month July	eath Day	^y 2007 Year	3. Time of Death 4:34 A.M
3	Examir		4a. Facility Name (If not institution,	_			or Location of Death	1		County of Death	
			Baltimore-Washi			Glen B		T. D. (D.		nne Arur	
	Funeral Director		5. Social Security Number 213-54-2106 Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 F	e (In yrs. last birthday 81 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Dec 2	$\overset{rin}{0}, \overset{Year}{1}$	925 Ger	place (State or Foreign intry) many
	e Maryland a-f show lifted at	ctor	10a. State 10b. County	Arundel	Glen Bu						10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			_	izen of What Cou	-
	s 23a	ral	202 St. James		Francis II O 140		061			nited St	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	11. Marital Status 1 ☐ Never Married ②□Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2XX If Yes, Give Year or Dates:	No	If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	
S O	72 ho natur	Completed by	15. Decedent' (Specify only highes	s Education t grade completed)	16a. Deco	edent's Usual Occu e kind of work done	pation during most of worked)	king	16b. K	ind of Business/li	ndustry
121	vithin ane. than '	ldu	Elementary/Secondary (0-12)	College (1-4or 5	D+)		•	_	Dh	armacy	
15 17	filed v Hygie ther t	ပ္သို	17. Father's Name (<i>First, Middle, L</i>	_ast)	ь	ookkeeppe	18. Mother's Nam	ne (First, Middle	J		
an	d be ental ked o	To Be	Joseph Neuman	•			Frid		nown	,	
Baltimore, Maryland 21215-0036	nd 2 shou aith and M 27 Is mar r traumat	-	19a. Informant's Name/Relationsh Domingo Monreal	ip (Type. Print)		ing Address <i>(Stree</i> 2 St. Jam	tand Number or Ru es Place			or Town, State, Zi ie, MD 2	
Jre,	ss 1 a of Hea item		20a. Method of Disposition	0.77	20b. Place of Disp	osition (Name of ematory or other pla	ace) T	Date	20c. Lo	ocation - City or T	own, State
Ĕ	Page ment ant: If ury o		1 ,∏x Burial 2 □Cremation 4 □Donation 5 □ Other (<i>St</i>		Crownsvi	lle MD Ve	t. Cem. J	uly06,	Co	wnsville	e, MD
Balt	permit. Departimont amy inj		21. Signature of Funeral Service L	Licensee			ess of Facility ddick Fun Hwy. S.E.				.061
	- 14		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	the death. Do not en	nter the mode of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a_ (u	ng (ance	2				Conset and Death
2	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
ş	ni g	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):						
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6 .							
60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
9289	ate be hysici the bu	lical		d							
9 ×	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome	nf pregnancy					22151 (17	
.O. Box	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the table.	Physician/Medical	23b. Was decedent pregnant in the past 13 months? 1 ☐ Yes 2 ☐ Uo 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	су			23d. Date of deli	very Day Year
rds, P.	quires that n signed b ıld be deta	ğ	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	>/	•		the cause of death?
Vital Records,	he law rec e has bee ige 2 shou	Completed						24a. Was auto perfe		prior to c	copsy findings available ompletion of cause of
ta	an: T tificati tor, pa		25. Was case referred to medical				26. Place of Dea			1∐Yes	2 No
>	ysici iis cer direc'	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatie	ent 3 DOA Ot	hor:			6 □Other (Spec	ify)
0	Attending Physician: r death. ector: After this certifica by the funeral director, I	L:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	of 28c. Inju	iry at ork?	28d. Describe	how inju	ry occurred	
Sio	tendil eath. tor: A the fu	catic	2 Accident investig 3 Suicide 6 Could n	ation			Yes 2 □No				
Division or	al or At after d I Direct d in by	Certification:	4 Homicide determi	nod Zoe. Place of Ing	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (City or To	(Street ar wп, State	nd Number or Ru e)	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		g Physician: To the best Examiner: On the basis o and manner st	f examination and/or						
	To the within To the COMP	Me	29b. Signature and title of certifier		_	29c. Licen	se number		29d. Da	te signed (Month	, Day, Year)
	4		Mar	ay_n	''>		27502		٧	ey 2,	2007
	0		30. Name and address of person of Yudhish Mo	ruan 30	5 Host	ifal Dr	39505 Glan 1	Sum	·e,	MD. 2	21061
	Sta Regist		31. Date filed (Month, Day, Year)	2007 32 Registr	ar's Signature	rester					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 20**0**7 James Jerome Metzger Sr. 1, 3:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HCR Manor Care Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 XM 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 23, 1918 9. Birthplace (State or Foreign Funeral 88 394-09-0134 Illinois Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at Director 1 TYes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Blvd 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Set-Up Man permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Metzger Barbara Jurschitza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Metzger, Son 4515 Willard Avenue, Apt-2310 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/02/07 Baltimore, Maryland 21. Signature of Funeral Service digensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rectal Carcinoma **Physician** In situ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **Glavcoma** 2 No 3 Probably 4 Onknown 1 ☐ Yes Be Completed Trigeminal Neuralgia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy performed 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural after death. 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funerail 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

eti

Viny Ganti 31. Date filed (Month, Day, Year)

19529 Doctors Drive Germantown, MD 20876 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DL11162 MD

July 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Melotte AM Martinus 0 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samantan Hospital Saltimore 8. Date of Birth (Month, Day) Year)
July 21, 1947 Neatherlands If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7 Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 59 Months Days Hours 1₽M 2□ F Yrs. 288-76-0481 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow is 1 and 2 should be filed within 72 hours after deeth with the Maryla of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f ehoy other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Harford Maryland Director Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 B Franklin Street 21078 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Vivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Golf Course 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johannes Melotte Lucia Maka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 is m eny Injury or other treum Jacqueline Amrhein, Friend 1514 Lady Anne Court Jarrettsville, Maryland 21084 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/02/07 Baltimore, Maryland 21. Signature of Funeral Service I Icensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTAT Physician IC SQUAMOUS CELL Ca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 D No 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1. Inpatient 2 TER/Outpatient 3 DOA this After this funeral o 27. Manner Death 28c. fnjury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Mural 5 Pending 1 ☐ Yes 2 ☐ No efter death. i Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours e To the Funeral E 29a. Certifier Medical Official the cause of the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number RESODO JUNE 30, 2007 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) | HANSA WASSEM, 5601 LOCHRAVEN
BLVD, BALTIHORE, 21239

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 3 2007

32 Registrar's Signature

			1 - For State Registrar	State o	of Maryla		artment of F rtificate of		Mental Hy	giene Reg. No	ma	9
			Decedent's Name (First, Midd	le, Last)					2. Date of De	eath		3. Time of Death
	Physici /Medic		Frederick W.	Michael I	II				June	30	200 ^{Year}	12:30 P M
	Examin		4a. Facility Name (If not institution		mber)		4b. City, Town, o		th	40	. County of Deat	h
			17917 Dumfries					Lney			Montgom	
В	Funeral		5. Social Security Number	6. Sex 1 1 M 2 □ F		s, last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir	. (Month, D	ay, Year) Co	hplace (State or Foreign untry)
100	Director		373-60-3473 Usual Residence of Decedent		53	3	<u> </u>		June	23,	1954 1	New Jersey
	yland Iow at		10a. State 10b. County	,	10c. (City, Town or Lo	cation					10d. Inside City Limits
	a-f st	to	Maryland Mont	gomery			01ney					1 X Yes 2 □ No
	or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?
	23a ust b		17917 Dumfri				20832				ited Sta	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried Armed Fo	2☑ No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2\(\overline{L}\) No	lispanic Origin? (an, Mexican, Pue <i>Sp</i> ec <i>ify:</i>	Specify Yes or Nerto Rican, etc.)	o-	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	72 ho natur iical I	Completed	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	ation during most of w	orkina	16b. k	(ind of Business/	Industry
21	ithin ne. nan "	g	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired		Sining	D.		antimant Char
121	12 should be filed w n and Mental Hygier is marked other traumatic event, th		12 17. Father's Name (<i>First, Middle</i>	(act)		U.I	othing S		ame (First, Middle			artment Store
Maryland	l be findal Hed of orther	Be			·				red Char		•	
<u>S</u>	hould id Me mark matic	은	Frederick W. 19a. Informant's Name/Relation:			19h Maili	ng Address (Street					Zin Cade)
Za	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		Patricia A. Mi		ster							and 21704
ē,	s 1 and 2 soft Health an Item 27 is other trau		20a. Method of Disposition		20b	Place of Disno	eition (Name of	1	Date		ocation - City or	
m 0	Pages Tent of Int: If Its Iry or o		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (State	Gate of	matory or other place Heaven tery	July	6, 2007	Silv	zer Spri	ng, Maryland
Baltimore,	permit. Page Department of Important: If any injury or		21. Signatule of Funeral Service	Licensee	M014	2	2. Name and Addre ckville, ckville,	ss of Facility RO	hert A.	Piimi	hrev Fu	neral Home/
	1800		23a. Pan1. Enter the disease, shock, or heart failure. Li	r complications that of t only one cause on e	caused the de	ath. Do not en	er the mode of dyir	ng, such as cardi	ac or respiratory a	arrest,	117	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Ac	ute Co	ronary	Insuffic	iency				Onset and Death 30 Minutes
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):						_
		er	Sequentially list conditions,	D	perten							5 Years
i)	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	€ Due to	(UI as a CUIIsi	equence on.						
/	ficate be executed physician and is the burial-transit	Examin	that initiated events resulting in death) Last	c	(or as a conse	equence of):						
68760,	e be (sicial	edical I		C _d								
		ledi										
P.O. Box	at the death certiff by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 ☐ Fe nant at time o	etal death 3	□Ectopic pregnanc □Other (specify) _	/			23d. Date of del Month	ivery Day Year
	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant condit	ions contributing to d	leath but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ğ	w require been sig should b								1 🗆	Yes 2	2□No 3□Pr	obably 4 ⊠Unknown
or Vital Records,	The ate h	Completed							24a. Was auto perf 1 <mark>∑</mark> Yes	an ppsy ormed? 2 □ N	prior to death?	topsy findings available completion of cause of 2⊠ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only	one)		
0	Phys this al dir	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		ER/Outpatier		4 LI Nursing	Home 5X Res	_		cify)
on	ing After	tion	1⊠Natural 5 ☐ Pendi	/8.4	nth, Day Year)		Wor	k? Yes 2 □ No	26d. Describe	now inju	iry occurred	
Division	I or Attending after death. Director: After I in by the funer	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place	e of injury - At ling, etc. <i>(Sp</i> e	home, farm, str cify)	eet, factory, office		28f. Location City or To			ıral Route Number,
	Hospita 4 hours Funeral tely filled	Medical Ce		ng Physician: To the								
	To the within 2 To the сотрые	Me	29b. Signature and title of certific				29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year)
	->-0		Devett "	Morrison	in		D47	682		.11	uly 2, 2	007
	()		30. Name and address of person	who completed caus	se of death (It	em 23a) (Type,				- 01		
	0		Bennett Morriso				ndy Sprin	ng Road,	Olney,	Mary	1and 208	332
	Sta		31. Date filed (Month, Day, Year	1007	Registrar's Sig	nature						
	Registr	ar	JUL 0 3	3 ZUU1 /	Allen .	H. Ap	we					

DHMH 17 Rev 1/2001

Villiam G. Madk		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg, No.
Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Mostly Douglest Same of Death
ledical Exami	ner	William George Madkins June 28, 2007
<i>y</i>		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		216-30-7582 XXM 2 F 73 Yrs. Months Days Hours Min. Feb.8,1934 Foreign Country) MD
5 JE 4 STEEL SAMS 1		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
ow any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 探 No.
ne Maryland or 28a-f show ffed at once.	Director	10e. Street and Number 10f. Zip Code 10g. Clitizen of What Country?
the Ma a or 28 tiffed_	Dire	332 Worton Road 21221 USA
after death with the Maryland al", or items 23a or 28a-f sh nicr must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, If Yes, specify Quban, Mexican, Puerto Rican, etc.) White, etc.
or deat	Fun	1 X Yes 2 No
urs afte tural", unine	l by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
15-0036 filed within 72 hours I Hygiene. ed other than "natur, t, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) SSN Supervisor Federal Gov.
5-0036 fled within 72 Hygiene. I other than "	dmc	12th -
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tina Madkins
2121 ould be fi Mental marked ic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0 permit Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the 1		Judith Madkins / wife 332 Worton Road Baltimore MD 21221
or Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:
Balt permit Depart Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva
/Medical		Immediate Cause (Final disease a. Multiple Injuries
diminor		or condition resulting in death) Due to (or as a consequence of):
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
cuted md transit		d.
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burnal - transit	Medical	UNPENDED AMENDED
876(iificate ng phy as the b	n/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
Box 6876 death certificat he attending ph d for use as the	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
D. BC t the der by the a	Physician//	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.O. res that the signed by be detac	ρ	1 Yes 2 ✔ No 3 Probably 4 Unknown
cords, law requir has been s	letec	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco The law cate has	Completed	gerformed? death? 1 V yes 2 No 1 V yes 2 No
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Be C	25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysici	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:
n of \alpha oding Phy. h. After tl		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. 2007 Pending 28b. Time of Injury 1628 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Subject fell
Division rs after death.	icati	2 V Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Yard control of the determined (
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signal fire and tittle of continue 29d. Date signed (Month, Day, Year)
	Ē	O.C.M.E. June 29, 2007
— _		30. Name and address of person who com/lete cause of death (Item 23a)
10	5 (d	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S ⁱ Regis	tate trar	14 - 0 0 0000 N
DHMH 17 Rev 1/2		ORGINAL
		O I VOIT I LE

/lichael	Anthony	Murray
----------	---------	--------

State of Maryland	Department	of Health	and Mental	Hygiene

		1- For State Registrar	Certi	ificate of	Death		Re	g. No.	2,00	
Physicia	an/	Decedent's Name (First, Middle,Last)	·				Date of Death Month		3. Time of Death	
dical Exami	iner	Michael A. Mur					June 30, 2	007	1421 hrs	
		4a. Facility Name (if not institution, give	street and number)	4	b. City, Town, or Baltimore	Location of De	eath	4c. County of Deat	h	
		John Hopkins Bayview MC 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hidhdau)	If Under 1 Yea	ar If Under 24	Ure 8 Date of Birt	h(MM/DD/YYYY) 9. Bi	rthnlace (State or	
Funeral Director					Months Day		Min. $5-2-1$	Fore	gn	
Director			M 2 F 48	Yrs.		47	3-2-1	.939	ountry) MD	
any		Usual Residence of Decedent 10a. State 10b. County	10c, City, T	own or Location	on				10d. Inside City Limits	
8		MD Baltimo	, ,	ndalk					1 Yes 2 No	
yland a-f sh	tor	10e. Street and Number	<i>D</i> u	- I	10f. Zip Code		110	og. Citizen of What Co		
e Mar or 28,	Director				· ·					
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f show a the Medical Examiner must be notified at once.		15 Maryland Ave	n u e 12. Was Decedent Ever in U.S.	12 Was	2122		(Specify Yes or No-	USA	rican Indian, Black,	
ath w items	uneral	1 X Never Married 2 Married	Armed Forces?		es, specify Cuba			White, etc.	ricali indian, black,	
ter de	F		1 Yes 2 X No	1	Yes 2 X No	specify:		Specify: Tat	hite	
036 ithin 72 hours after. ine. r than "natural"	d by	15. Decedent's Education (Specify only	or Dates:	l6a. Decedent	's Usual Occupa	tion (Give kind		16b. Kind of Business		
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life	e. DO NOT use	retired)			
036 tthin ne.	ldu	12			Disabl	ed		Disab	1ed	
5-0036 iled within 7 Hygiene.	Col	17. Father's Name (First, Middle, Last)			<u> </u>	18.Mother's N	ame (First, Middle, M			
2121 buld be fil Mental F marked ic event,	Be	Jessie Murray,				Mo1	lie C. G	Gallop		
D 2121 should be fi and Mental 77 is marked	70	19a. Informant's Name/Relationship (Ty						ber, City or Town, Stat		
E 0 - 0 E		Barbara Murray		15 M	iarylar	d Ave	., Dunda	1k, MD 2	1222	
re, N s I and of Healtl If item		20a. Method of Disposition 1 X Burial 2 Cremation 3		ace of Disposi ematory or oth	tion (Name of ce er place)	metery,	Date	20c. Location - City of	r I own, State	
imore Pages 1. nent of H ant: If it or other		4 Donation 5 Other Specify:	Oal	k Lawr	Cemet	ery	7-6-07	Baltim	ore, MD	
Baltimore, permit Pages I ar Department of Her Important: If ite injury or other ir		21. Signature of Funeral Service Licens	ee	22. N	ame and Addres	s of Facility	Bradley-	Ashton F	ore, MD uneral Homa	
ದಾ ಕಳ='ಕ		That the		PA	, 2134	Will	ow Sprin	g Road,	21222	
Physician /Medical		23a. Part I. Enter the disease, or compli- failure. List only one cause on each	h line.				ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
/wedicar			lypertensive Atheroscle		ovascular Di	sease			Death	
		h	ue to (or as a consequence of):							
~	er	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of):							
	mine	cause. Enter Underlying Cause (Disease or injury that initiated								
led nsit	Exal	events resulting in death) Last Due to (or as a consequence of):								
Records, P.O. Box 68760, The law requires that the death certificate be executed toate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ical									
760, ficate be g physicia the buria	/Medical	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d. Date of delive	erv	
6876 certificat nding phy se as the		23b. Was decedent pregnant in the past 12 months?	1 Live birth		al death 3	Ectopic pre	egnancy	Month	Day Year	
Box 68: e death certifi the attending ed for use as it	sicia	1 Yes 2 No 9 Unknown	4 Pregnant at time of deal	th 5 Oth	er (Specify)					
he dea	Physiciar	Part II. Other significant conditions	9 Unknown	ulting in the	adorl in a payon	siven in Part I	230 Did to	bacco use contribute t	o the cause of death?	
ires that the signed by	by I	Obesity	contributing to death but not res	unting in the u	nderlying cause	given in Fait i.			obably 4 V Unknown	
S, I		Obesity					24a. Was a		autopsy findings available	
cords law requirents has been a	ble						autop	sy prior to	completion of cause of	
of Vital Records, ng Physician: The law require Niter this certificate has been si neral director, page 2 should b	Completed								res 2 No	
tal Rection: The certificate ector, page	Be (25. Was case referred to medical examiner?	ospital:			e of Death (Ch Other ₄ N				
F Vi Physi r this	ဥ	1 ✓ Yes 2 No	i inpatient 2 V i					Residence 6 Oth	er:	
n of ding P 1. After funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Ir		ury at Work? Yes 2 No		now injury occurred		
SiOI Attender death ctor:	cati	2 Accident Pending Investigatio	n Alban				l	Street and Street and F	Dural Durah Number City	
Division spital or Attendi hours after death. Interal Director: /	Certification;	3 Suicide 6 Could not b	e 28e. Place of Injury - At hor (Specify)	ne, tarm, stree	t, ractory, onice	bullaing, etc.	or Town, S		Rural Route Number, City	
E 8 E		4 Homicide						2/2) === ===============================		
4. 4. 0	ica	(Check only Certifying Physicia	 To the best of my knowledge On the basis of examination and 							
To the within To the comple	Medical		and manner stated.		29c. Licen			29d. Date signed (M		
		1 1 /10	en mos			.M.E.		July 1, 2007	,	
4		20 Name and address of sames when		23a)						
1		30. Name and address of person who con Tasha Greenberg MD. A	ssistant Medical Examir		Penn Street,	Baltimore,	MD 21201			
	tate		32. Registrar's Signature	e a						
Reais	THE STATE OF			& Bon	dis					

DHMH 17 Rev 1/2001

.

OCME

ORIĞI

ORIGINAL

			For State Registrar	State of Marylan	•	rtment of F			giene	Ī	21351
16	Physici /Medic		1. Decedent's Name (First, Middle, Last,)	MONR	OE		2. Date of Dea Month O		ear 7	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give MERCY MED) 5. Social Security Number 6. Se	CAL CENT	last birthday) _		r Location of Death T MORE If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat		MOK	RECITY place (State or Foreign
	death with the Maryland ms 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	12	y. Town or Loc	ation TIMOR		0020	2007	1	Od. Inside City Limits 1 X Yes 2 □ No
	ath with the 23a or 28	ral Director	10e. Street and Number 12 E. PRESTON	ST. APT.			62		10g. Citizen of Wh	SA	
5-0036	urs after al', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of H Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Black, Specify:	White,	
-C1215	d within 72 hours jiene. r than "natural"	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of work	ing	16b. Kind of Busi	ness/Inc	dustry
yland,	Mental Hyg Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last)	J	_		18. Mother's Nam		Maiden Sumame)	A	YROE
baitimore, mary	pernit. Pages 1 and 2 sho Department of Health and N Importent: If Item 27 Ie ma any injury or other trauma 2006		19a. Informant's Name/Relationship (T) AYU ← E L M O D R O E 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Line 18	MOTHER 20b. F	12 F	PREST	nekus 6-2	0+2 B	20c. Location - Co	ity or To	2(202 own, State
	Physician /Medical		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line. EXTREME Due to (or as a conseq			ng, such as cardiac	or respiratory	refit.		Approximate Interval Between Onset and Death
,00/8	certificate be executed as a rding physician and ause as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a con							
O. BOX 6	death certific e attending p od for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	33c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date Month		ery Day Year
ras, r	requires that the ween signed by th hould be detache	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did to	obacco use contrib es 2 No 3	ute to th	
	The law ate has b page 2 si	Completed						24a. Was autop perfor	med? de	ere autor or to cor ath? Yes	psy findings available mpletion of cause of 2) No
or vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 KInpatient 2 □	ER/Outpatient	3□ DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho		<i>ne)</i> dence 6 □Other	(Specif)	у)
VISION 0	ttending death. tor: After the fune	ertification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yeer) 28e. Place of Injury - At he building, etc. (Specif	28b. Time of Injury		ryat rk? Yes 2 □No		Street and Number		al Route Number,
5	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	O	29a. Certifier (Certifying Phy	sician: To the best of my kno	wledge, death	occurred at the til	me, date and place.	and due to the	cause(s) and mann	ner as sf	tated.
	o the Ho ithin 24 f	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or inve	estigation, in my o			date and place, an 29d. Date signed (
	- 3 - 8		1 Xan	-mp		P	21112		06 26	, 2	007
C	7		KATHLEEN SLON		350 y	ST. PAU	LST. SU	ITE 14	3 BAL	TM	use Mi)
	Sta Registi		31. Date filed (Month, Dey, Year) JUL 0 3 200	3 Registrar's Signa	MILO POPULA						31718

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Salvador Malungcot	Mauyao
--------------------	--------

		1- For State Certificate of De Registrar	eath	Reg.	No.	1 1.00	
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle,Last) Salvador Malungcot Mauyao	4	2. Date of Death	av Year	3. Time of Death 1036 hrs	
		,	City, Town, or Location of Death exington Park		4c. County of Death St. Mary's		
Funeral Director				8. Date of Birth(I	MM/DD/YYYY) 9. Birth Foreign Cou	place (State or Philippines	
after death with the Maryland al", or items 23a or 28a-f show any- ner must be notified at once.	Funeral Director	21045 Willows Drive 2 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	ark f. Zip Code 0653 ecedent of Hispanic Origin? (Sispecify Cuban, Mexican, Puerto Sispecify:	Phoecify Yes or No-		an Indian, Black,	
21215-0036 buld, be filed within 72 hours aft Mental Hygiene. marked other than "natural" cevent, the Medical Examing	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Francisco Mauyao	isual Occupation (Give kind of of of working life. DO NOT use retience 18.Mother's Name Isabell	red) e (First, Middle, Mai Malungco	Retail iden Surname)	dustry	
e, MD 2 and 2 shou Health and N item 27 is n		Noel Basobas Mauyao / Son 200 Place of Disposition	dress (Street and Number or Villows Drive, n (Name of cemetery, place)	Lexingtor	n Park, MD	20653	
Baltimor permit. Pages 1 Department of 1 Important: If	_	22. Name 22. Name 22. Name 28. Part I. Enter the disease, or complications that caused the death. Do not enter the management of the death. Do not enter the management of the death.	e and Address of Facility Ren E. Baltimore	don-Baile St., Balt	ey Funeral timore, MD	Home, PA	
/Medical £xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiova Due to (or as a consequence of):	ascular Disease			Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting injury that initiated events resulting injury that injury that injury that injury that in	· · · · · · · · · · · · · · · · · · ·				
760, cate be executed physician and the burial - transit	Medical Ex	d. UNPENDED AMENDED					
Box 68760, e death certificate be e the attending physicial d for use as the burial	23b. Was decedent pregnant in the past 12 months? 1						
S, P.O. B uires that the d n signed by the	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	1 Yes	2 No 3 ✓ Prob		
tal Records, cian: The law requir certificate has been sector, page 2 should la	Completed		00 Diago of Dogsh (Ohoo)	24a. Was an autopsy perform	prior to co	completion of cause of	
ician: s certi irector	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3	26.Place of Death (Check		esidence 6 🗸 Other	: Scene	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	ation: To	27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	y 28c. Injury at Work?	28d. Describe ho	w injury occurred	lees-	
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, for a Homicide (Specify)		or Town, Sta	ite)	ral Route Number, City	
To the Hospital within 24 hours To the Finneral completely fille	Medical	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one one Medical Examiner: On the basis of examination and/or investigation.	at the time, date and place, an , in my opinion, death occurred	d due to the cause(at the time, date ar	(s) and manner as state nd place, and due to th	ed. e cause(s)	
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Moi		
1		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Si	treet, Baltimore, MD 21	201			
	tate	11 11 11 11 11 11 11 11 20 20 20 20 20 20 20 20 20 20 20 20 20	20				
Regis DHMH 17 Rev 1/2		OCME ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

Tancisco Mendes-Mena	Francisco	Mendes-Mejia
----------------------	-----------	--------------

		1-For State Control of Health and Mental Hy Registrar Certificate of Death	• •	eg. No.	7 7125
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)	2. Date of Deat	th	3. Time of Death
VIEUICAI EXAIIII	IC I	Francisco Mendes-Mejia 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 23, 2	4c. County of Deat	0427 hrs
		Route 135 Westernport Road Westernport		Allegany	'
Funeral Director		5. Social Security Number 1 X M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Nonths Days Hours Min.	_	th(MM/DD/YYYY) 9. Bit -1985 Co	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland	ō	Chiapas Tuxtla Gutierrez	0.7		1 Yes 2 X No
th the Maryland	Director	10e. Street and Number 10f. Zip Code 29049	ľ	0g. Citizen of What Cou Mexico	ntry?
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	/ Funera	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 XX Yes 2 No specify: MeX:	Rican, etc.)	- 14. Race - Amer White, etc. Specify: Whi	ican Indian, Black,
10	od by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	16b. Kind of Business/	Industry
5-0036 led within 72 h Hygiene. other than "n the Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) Pallet Builder	red)	Shipping	
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Alvaro Mejia Zunun Maria de		Maiden Surname) n Mendes Di	27
21218 hould be fill nd Mental H is marked atic event, t		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
ore, MD ss 1 and 2 sh of Health and If item 27 is ner traumat		Manuel Cardenas / Friend P.O. Box 393 Keyser, V			
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Chiapas Cemetery	Date 11-2007	20c. Location - City or Chiapas, M	
Baltimo permit. Page: Department o		21. Signature of Funeral Service Licensee M01452 22. Name and Address of Facility Rer 2818 E. Baltimore S	St., Bal	iley Funera Ltimore, MD	
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of):			Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
,	amine	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death). Last Use to (or as a consequence of):			
	al Exa	d			
'60, cate be exc physician he burial -	Medical	XUNPENDED #23a.27.28a-f. perMF.g869. 7/25/07.TT	_		
1876 rtificate ing phy as the	ڇ اڇ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of delivery Month	/ Day Year
Box 687 e death certific the attending p ed for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown		0	
O. B. at the de lby the lached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
s, P.O.	od by		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
Records, The law require ficate has been si, page 2 should b	Completed		24a. Was a autops	sy prior to d	topsy findings available ompletion of cause of
tal Rec	팅		perform 1 ✓ Yes 2		s 2 No
ital ician: s certif	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing			
of Ving Phys	음	1 Ves 2 No Impatient 2 Erroutpatient 3 DOA 4 Nursing		Residence 6 V Other	
ion (tending eath top: Att	딅	Natural 5 Pending Investigation Fnd 6/23/2007 Fnd 4:10 am	subject w road and	ow injury occurred las driver of overturned	car that left
Division of Vital tal or Attending Physician: Its after death all Director: After this certified in by the funeral director.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru	ral Route Number, City Sternport Rd
y me hou pai		4 Homicide determined (Specify) off roadway (in burning car) 129a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and off control of the cont	Westerpor	t, MD	
To the Ho within 24 P To the Fm		one) Medical Examiner: On/the basis of examination and/or investigation, in my opinion, death occurred at and channer stated		ind place, and due to the	e cause(s)
المر المر	≥ :	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mor June 25, 2007	nth, Day, Year)
2 of P	\$	30. Name and address of person who completed cause of death (Item 23a)			
8		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
Stat Registra	•	31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year Month McLain John 21 6 2007 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months 65 9-16-1941 10c. City, Town or Location 10b. County NA Baltimore

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:55a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 3041 Kenyon Avenue Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 219-38-3640 Director MO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State notified at V☐Yes 2☐No Director 28a-f Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 3041 Kenyon Ave. 21213 Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 ☐ If Xes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: Rlack Specify Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bethlehem Steel 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin ျ McLain Louise Di xon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trauonce. Linda McLain Wife 3041 Kenyon Ave., Baltimore, 21213 Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 7-03-07 Owings Mills/ Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East M Warne 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meta Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed ding physician and ise as the burial-tra resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 this Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760, within 24 hours a

> 5+1 M Dar 115

29d. Date signed (Month. Dav. Year) June 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21234 5601

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20bper fh 9869 7-5-07 vt. State of Maryland Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28^{Day} Month 200^{Year} **Physician** David Boone McElrov June 8:50 Αм /Medical 4c. County of Death Baltimore 4a. Facilify Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Gilchrist Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 09-22-1952 1 X M 2□ F Months Days Hours Min 54 216-62-0743 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Parkville MD Baltimore 1 □Yes 2 No Director 10f. Zip Code 21234 10g. Citizen of What Country? 10e. Street and Number 8204 Evergreen Drive USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No If Yes, Give Year or Dates: White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5^{College (1-4or 5+)} Elementary/Secondary (0-12) Graphic Designor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Eileen Boone <u> William McElroy</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sara McElroy/Daughter 18 English Saddle Ct., Parkton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20a. Method of Disposition Date 20c. Location - City or Town, State July 3,2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAG **Physician** d /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initial accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequency of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 4☐Pregnant at time of death 9☐Unknown signed by the at d be detached for 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes 2∐No the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of crtifier June 28, 2007 and address of person who completed cause of death (Item 23a) (Type, Print) Chales St. Balts. Md 20204 bm(6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2007 Registrar

DHMH 17 Rev 1/2001

McBrou, D

7-04811 Iyan Michael M	anna			or Print in BI of Maryland							ible.	
71		1- For State Registrar	Otate	or waryland	•	ificate o			critarriy		g. No.	7 12 1 3 5
Physicia Medical Exami	an/	1. Decedent's Nam	e (First, Middle,La Mich		anna					2. Date of Death Month June 24, 20	n Day Year	3. Time of Death 2040 hrs
		4a. Facility Name (i 416 Darby L	lf not institution, gi	ve street and number)			4b. City, T Belair	own, or Locat	ion of Death		4c. County of Deat Harford	h
Funeral Director		5. Social Security N 217-02-69	950	6ex 7. A9	e (In yrs. las 25	-	Months		Jnder 24Hrs. ours Min.	-	7, 1982 co	rthplace (State or gn puntry)Maryland
d how any	*******	Usual Residence of 10a. State	10b. County Harfor	·d		own or Loca						10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Nu		1 17		JOE ME	10f. Zip	^{∞de}	-	10	g. Citizen of What Cou	intry?
5 72 bours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 XNever Marri	ed 2 Marrie	1 Yes 2			as Decede Yes, specif	nt of Hispanic y Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
bours afte "natural", Examiner	ρ	3 Widowed 15. Decedent's Ed Elementary/Second	ducation (Specify o	d If Yes, Give Yeer or Dates: only highest grade cor College (1-4 or			nt's Usual (No specification (Civing life, DO I	Give kind of w		Specify: W 16b. Kind of Business	hite /Industry
21215-0036 uld be filed within 72 bours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Completed	12 17. Father's Name				Ma	anage		other's Name	(First, Middle, M	Bar/Resta Baiden Surname)	urant
1215 Id be file Aental Hy narked o	Be	Phili	ip	Manna	a, Jr.				Denis	е	DeSar	ntis
D 21 should and Me 7 is ma	٢	19a. Informant's Na								F	ber, City or Town, Stat	
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Dis	Manna-mot	THET.		ace of Dispo	sition (Nan	ne of cemeter		Bel Ai:	r , MD 2101 20c. Location - City o	
Baltimore, permit. Pages 1 at Department of He. Important: If it injury or other tr		4 Donation 5	Other Specif	Removal from St	" Hil	ematory or of	Serv	Corp		9/07	Towson, M	
Bal permi Depar Impo injur		21. Signature of Fu	Ineral Service Lice	^{nsee} William	G. Da		Name and	Vary R	Ruc	k Towson	n Funeral D 21284	Home, Inc.
Physician /w. cltral :aminer	ner		ily one cause on e Final disease and in death) inditions, inmediate	plications that caused each line. Contact Gunsho Due to (or as a cons b. Due to (or as a cons	ot Wound equence of):	of Chest		f dying, such	as cardiac oi	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
executed in and ill-transit	I Examiner	(Disease or injury t events resulting in	hat initiated C	Due to (or as a cons	equence of):							
D, be exe sician a	edical	UNPENDED		AMENDED								
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Ilospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown							ncy	23d. Date of delive Month	ry Day Year	
s, P.O. Be ires that the de signed by the		Part II. Other signi	ificant conditions	contributing to deat	h but not res	sulting in the	underlying	cause given	in Part I.		bacco use contribute to	the cause of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been seled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed by									24a. Was a autops perfor 1 Yes 2	sy prior to med? death?	
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case refer examiner?		Hospital:	ent 2 E	R/Outpatien		26.Place of Do			Residence 6 ✔ Othe	er: Scene
on of Vir ending Physicath or: After this he funeral dir	tion: To	27. Manner of Deat 1 Natural	5 Pending	28a. Date of Inju (Month, Day) Jun 21, 2007	Jry :	28b. Time of UNKNOW!	Injury 2	28c. Injury at N	Work?		ow injury occurred	3. 300110
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined (Specify) Townhouse / Rowhouse 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 416 Darby Lane, Belair, Md.							ural Route Number, City			
the Hos in 24 h he Fun pletely		29a. Certifier (Check only one) 2									e(s) and manner as sta and place, and due to t	
To To Com	Medical	29b. Signature and		and manner stated.				. License nur			29d. Date signed (M	
		Mulus 30. Name and addr	14 SULLS	sell MT	leath (Item 3	23a)		O.C.M.E.			June 25, 2007	
6		Melissa Bra		Assistant Medica	,		Penn Sti	eet, Baltin	nore, MD	21201		
St Regis	ate trar	31. Date filed (Mon		32. Pogistra	ır's Signatur	L do	we					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

03

2007

			- For	se Type or Print i State of Maryl	and / De	partment of h	lealth a			_egible.		
	Physicia /Modis		1 - State RegIstrar 1. Decedent's Name (First, Middi HERBERT	e, Last)	C	ertificate of MENSH	Death	2. Date of D Month JUNE	Reg. No. eath Day	2007	3. Time of 6:15	f Death
)	/Medic Examin		4a. Facility Name (If not institutio	n, give street and number) - MEDICAL CENT		4b. City, Town, c		Death	4c. (County of Dea	th	
	Funeral Director		5. Social Security Number 212-22-4297 Usual Residence of Decedent	6. Sex 7. Age (In 81	yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of Bi (Month, D 05/11/	irth ay, <i>Year)</i> 1926	9. Bir	thplace (State of ountry) MD	or Foreign
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Director		BALTIMORE 10c	OWING	S MILLS						ity Limits
	with the		10e. Street and Number	ED WAY #104		10f. Zip Code			10g. Citiz	en of What Co	,	
	r death	Funeral	3440 ASSOCIATI 11. Marital Status	12. Was Decedent Ever i	n U.S. 10	21117 B. Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	0- 1	4. Race - Ame Black, Whit	erican Indian,	
yiana 21215-0036	hours afte tural", or it al Examin	þ	1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☑ Divorced	If * es, Give Year or Dates: AIR	FORCE	1 ☐ Yes 2 ☐ No	Specify:			Specify:	WHITE	
	be filed within 72 hours after death with the Marylar ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	— (Gi life	re kind of work done DO NOT use retire HANDISE M	during most od)	•	f	nd of Business	•	
		To Be C	17. Father's Name (<i>First, Middle,</i> MANUEL	Last) MENS	Н		18. Mother' CATHE	s Name <i>(First, Middle</i> RINE	e, Maiden S	Surname) SOLSK		
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relations					or Rural Route Num				
e,	es 1 and of Healt fitem 2 r other		SPENCER MENSH 20a. Method of Disposition	· ·	b. Place of Dis	position (Name of rematory or other place	i	D - REISTI		ation - City or		
ашшо	Pag ment ant: It ury o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	3 ☐ Removal from State Specify)	HEB SHA	LOM MEMOR	IAL 07	/01/2007				
Dai	permit. Depart Import any inj once.		21. Signature of Funeral Service	Licensee				SOL LEVIN WN ROAD -			•	ΣNΩ
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	. ^ ^	sequence of):			ardiac or respiratory			Approximat Interval Bet Onset and	e ween Death
00/00	te be executed ysician and te burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
O. DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	etal death	□Ectopic pregnanc	у		2	3d. Date of de Month		Year
7,5	ires that signed by I be deta		Part II. Other significant condition	ons contributing to death but not	resulting in the	underlying cause giv	en in Part I.		tobacco us		the cause of c	death?
necords,	The law requires that the death are has been signed by the atterbage 2 should be detached for u	Completed by	Peripher	al Joscu	100	Diser	se	24a. Was auto perf	s an opsy ormed?	24b. Were a prior to death?	utopsy findings completion of c	available
\	cian: ertifica ector, p	BeC	25. Was case referred to medica examiner?					1 Yes of Death (Check only	2/AUNo one)	T T T ES	2 □ No	
5	Physical this caral direction	5	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient :	2 ER/Outpati 28b. Time		4 A Nurs	sing Home 5 Res			ecify)	
200	ath. or: Afte	ation	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	g (Month, Day Yea gation		Wor	k? Yes 2∐No					
22	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifici completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	building, etc. (Sp	ecify)			City or To	iwn, State)		ural Route Num	iber,
	the Hosp iin 24 hou the Fune upletely fil	Medical	(Check only 2 Medical one)	ng Physician: To the best of my Examiner: On the basis of exam and manner stated.	knowledge, de nination and/or	investigation, in my	opinion, death	place, and due to the n occurred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s	3)
	with Con	2	29b. Signature and fittle of certifie	·		29c. Licens	e number	,	29d. Date	signed (Mon	th, Day, Year)	
	·e		30. Name and address of person	who completed cause of death (Item 23a) (Typo		17 C C	0		10710	21061	
	Sta	te	Jude Mune 31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	OAYU	9999	load	G/ev	n Kour	vie wi	7

		State of Maryland / Department of Health and	Mental Hy	/giene	
	_	1 - State Registrar Certificate of Death		Reg. No.	2125
Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Year	3. Firme of Death
/Medica		Darlie Marion Norwood	June	26 2007	7 6.307 M
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	th	4c. County of Dea	th
- Marian		Baltimore washing to Medical Center 61en Burnio 5. Social Security Number 6. Sex 9 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Bi	HANGE I	thplace (State or Foreign
Funeral Director		230-42-5823	. (Month, D	0,1932 Vir	ountry)
App. symm yer in		Usual Residence of Decedent	JAN J	U, 1932 VII	gilla
ylano how	. [10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Ma la-f s	cto	MD Anne Arundel Pasadena			1 □ Yes 2 X No
ith the	ie	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
ING 21213-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	8350 Catherine Ave 21122		USA	
er de Items ner m	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (3 if Yes, specify Cuban, Mexican, Pue if Yes, Give if Yes, Give if Yes, Give if Yes 2 ☒ No Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Race - Ame Black, Whit	
rs aft	by F	1 Never Married 2 Married 1 Yes 2 M No 3 Wildowed 4 Divorced Year or Dates:		Specify: p1	ack
2 hours aft atural", or cal Exami	e l	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
n "n	Bet	(Specify only highest grade completed) (Give kind of work done during most of work done during	orking	1	•
d with giene sr tha the I	Completed	12 Homemaker		Own_Home	
nd 2 should be filed Ith and Mental Hygi 127 Is marked other r traumatic event, ti	Be		me (First, Middle	e, Maiden Surname)	
should be and Mental is marked o	0	Thomas H. Allen Daisy M	1. Booke	r	
		19a. Informant's Name/Relationship (Type. Print) John F. Norwood/Husband 19b. Mailing Address (Street and Number or F. 8350 Catherine Ave. Pa			Zip Code)
and ealth n 27 ier tr	1				
Pages 1 nent of He int; If Iten iry or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
tmen tant; jury		4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 6/28		Baltimore,	MD
permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society	of Mary	land, Inc.	
40 = 60	-	299 Frederick Rd	Baltimor	e, MD 21228	Annualimete
100		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardie shock, or heart failure.		arrest,	Approximate Interval Between Onset and Death
Physician /Medical	- 1	Immediate Cause (Final disease or condition resulting in death)	715		
Examiner		Due to (or as a consequence or):	A	0.5	
	-	Sequentially list conditions, if any, leading to immediate b. A C UTE FLA FI Due to (or as a consequence of):	1/20	14	
Insit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c.			
in and ial-tra	Exa	resulting in death) Last Due to (or as a consequence of):			
physician and s the burial-transit	g	d			
rificate be executed g physician and as the burial-transit	ed				
attending for use as	Physician/Medical	IF FEMALE: 23b. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
ed fo	Sici	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
be detached	Ph S	9 Li Unknown	00 811		
igned be d	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS		tobacco use contribute to	
been sig	ed	UNDE TO TILLETTO	'_	Yes 2 No 3 P	robably 4 □Unknown
e 2 sl	Completed		24a. Wa	opsy prior to	utopsy findings available completion of cause of
cate has	င်			fórméd? death? 2⊠No 1 ☐ Yes	s 2.₹No
nis certificate director, pag	Be	examiner?	eath (Check only	one)	
this aldir	٥	i les 2410 i le l'Aursing	T	sidence 6 Other (Spe how injury occurred	ecify)
Hospital or Attending Physician: The law requires that the death certif 4 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	0	1 Natural 5 Pending (Month, Day Year) Injury Work?	Zou. Describe	now mjury occurred	
death death ctor: y the	icat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office	28f. Location	(Street and Number or R	Tural Route Number
after death Director: /	Certification:	4 Homicide determined building, etc. (Specify)		own, State)	
ospita hours uneral ly filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	ce, and due to the	e cause(s) and manner a	s stated.
e Ho 1 24 h ie Ful	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	curred at the time	e, date and place, and du	e to the cause(s)
Vithin 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
0		Same fam 10 D00618	32	JUNE 20	5 2007
1	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
V		301 Hospital Drive Glen Burnie, MD 21061			
State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cornelius Nicholson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 25, 2007 Medical Examiner 1746 hrs Cornelius Marvel Nicholson 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death 10502 Twin Knoll Way Upper Marlboro Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24Hrs **Funeral** oreign Months Days Hours Min Director 1 M 2 F Country) 241-23-7895 Yrs 36 197 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location E, Yes 2 No 28a-f show Halifax Roanoke Rapids Director 10g. Citizen of What Country? 10e. Street and Number with the 221 James Court 27870 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 * Married White, etc. Yes 2 * No If Yes. Give Yea Specify: Black Divorced Yes 2 No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Hem 27 is marked other that 12 Construction Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Leslie Nicholson
19a. Informant's Name/Relationship (Type, Print) Roxie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Amanda Nicholson</u> James Court <u>Roanoke</u> Rapids. NC 27870 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: Bapt. Ch l 30-2007Littleton. 22. Name and Address of Faction Signature of Funeral Service Licensee Funeral, Service C. ulfor led Balto. 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Cardiac tamponade Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Aortic dissection Sequentially list conditions. -Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Hypertensive cardiovascular disease الحن Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical X UNPENDED ending physician use as the burial -.27.perME.G869. 7/10/07 TT The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the a the detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown pleted peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s performed? death? certificate No 1 🗸 Yes 2 No Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 this ER/Outpatient 3 DOA 1 Yes No After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Director: Yes 2 No Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 26, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mbyth, Dy, 3ear 200 State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Charles June 30,2007 Edward Nea1 12:20AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1821 Norfolk Road Glen Burnie Anne Arundel | Months | Days | Hours | Min. | May 8 , 1940 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Months 67 216-36-4512 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Norfolk Road 21061 Funeral U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. Walter Neal Lillie Shinnaberry ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Norfolk Road Glen Burnie, MD 21061 Mrs. Carol Neal /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 3, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Brooklyn, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, Mol357 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Inter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 740 omo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of): Examine burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death 9∏Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 1 🗌 Yes 1☐ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 ☐ Pending investigation Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

o the Hospital or Attending Physician; The law requires that the death certificate be executed After t neral Director: A e Funeral I within 2

29b. Signature and title of certifie

2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

Medical

4 Homicide

6 Could not be determined

3 . Date filed (Month, Day, Year) State Registrar



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 200 :50 A M Wi2 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner SIC osin CR h R 701 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6, Sex 7. Age In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🗵 F Director Italy Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show at 1 ☐ Yes 2 ☐ No notified Director MD Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō be 6073 Augustine Ave. 21075 USA Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Seamstress 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental H Be Salvitor Oliviero Rosa Oliviero ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health tem 27 Sandra Committe Daughter 6073 Augustine Ave., Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 06/28/2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility L. Kaufman Funeral Home at MMP, INC Washington Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause yeach line. Immediate Cause (Final **Physician** 4 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 26/2 (D Pon Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the attending physician and de detached for use as the burial-transit ms resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown يم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform 1∐ Yes 2 🗔 (No Division or Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: al or Attending Physics after death. 4 ☐ Nursing Home P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 105 6/QOther (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗆 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and attle of certifier 29c. License number 29d. Date signed (Month, Day, Year, 2 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COBRIC 85 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For Amend Items Registrar	25,27,28a	-f per u		30667	707dhb			lo." [] .".	
	Physici		1. Decedent's Name (First, Middle, La Sarah M. O'Melia						2. Date of De Menth May		2007 Year	3. Time of Death 12:01 AM
	/Medio		4a. Facility Name (If not institution, give	e street and number)		4b.	City, Town, or	Location of Death		4	c. County of Deat	h
			30 Clyde Avenue					nsdowne				timore
	Funeral Director		5. Social Security Number 217-40-4625	Sex 7. Ag 1□ M X □ F	e (In yrs. last bii 100		iths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 2.	th 3, Yea	9. Birt 1906 Ma	hplace (State or Foreign untry) aryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	1					10d. Inside City Limits
	a-f sho	ctor	MD Bal	timore		Lans	downe					1 ☐ Yes 2 XNo
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 30 Clyde Avenue			10	f. Zip Code	21227			Citizen of What Co Jnited St	,
920	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:			Decedent of H , specify Cuba es 2 X No	ispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White Specify: W	
21215-0036	n 72 h "natu edical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give kind o	Usual Occup of work done of OT use retired	during most of wor	king	16b.	Kind of Business/	Industry
212	withi giene. r than the M	dwo	Elementary/Secondary (0-12)	College (1-4or	Se:	lf Emp		,		Cor	nfectiona	ary Store
פָּ	w = 0 &	Be C	17. Father's Name (First, Middle, Las	t)	<u> </u>			18. Mother's Nam	ne (First, Middle			
/lar		To E	George T. Biden					Annie B	. Narer			
Maryland	2 should and Men is marke aumatic	Ė	19a. Informant's Name/Relationship	(Type. Print)	198	b. Mailing Add	dress (Street	and Number or Ru	ral Route Numb	er, Cit	y or Town, State, 2	Zip Code)
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		Kathleen Pinheir)	4 20h Blace e	Rolli of Disposition	ng Far	m Court (Catonsv	11e	MD 2122 Location - City or	28
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		Meado	ery, cremator Wridge	y or other place Memor	ial 5 14	2-2007		,	•
量	# 보변증		21. Ign ure of Funeral Service Lice	4	Park	_	ne and Addre	J=14			lkridge, neral Hon	
Ba	permi Depa Impo any ii	10	* comolles	Laura	rech	2719	Hammo	nds Fry 1	Road, La	anso	downe, M	,
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death. Do ne.	not enter the	mode of dyir	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Subr	leval	Hemat						77-7-15
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequence	of):			/	/		
	7.4 统	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence	of):		OERTIFICATION A	1 //	/	MIER	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in doubt), act	C					VI. TIME)ICALE	XAMILLE	
o,	e exec an an irial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	of):		American	PPROVEDBY			
68760,	tificate be executed ig physician and as the burial-transit	edical		d				CERTIFICATION				
Box 6	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal deat		pic pregnancy er (specify)				23d. Date of del	livery Day Year
P.O.	the de	ysic	1 □ Yes 2 ☑No 9 □ Unknown	9☐Unknown	t time of death	3000	er (specify) _					
	ires that the de signed by the a l be detached t		Part II. Other significant conditions	-	out not resulting	in the underly	ring cause giv	en in Part I.		tobacc Yes		o the cause of death?
Sor	w require been sig should b	etec	Congestine Bears	- G. F.					24a. Was		1	utopsy findings available
or Vital Records,		Completed by	- State Succession	1 money					auto		prior to death?	completion of cause of 2 ☐ No
/ita	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:			Tout-	_26. Place of Dea	th (Check only	one)		
o	<u> </u>	<u>ا</u>	Yes 20 No 27. Manner of Death	1 ☐ Inpati	ent 2 ER/O	utpatient 3 Time of		4 🗆 Nursing n	ome 5 K Res 28d. Describe		6 Other (Spe	ecify)
	ftel	tion	1 ☑ Natural 5 ☐ Pending	FOUND ^{th, Di}	ay Year) Imk	Injury COOWIN N	28c. Injui Wor 1 1 □	k? Yes 2 X INo	Proba			
Division	Attend death sctor:	fica	3 Suicide 6 Could not I	10/07/200	jury - At home, fact. (Specify)	a arm, street, fa						ural Route Number, AV
á	s fter	Certification:	4 ☐ Homicide determined	FOUND:	Hone				Lansdow	me,	MD ateround:	30 Clyde Av
	To the Hospital or Attendi within 24 hours after death. To the Funeral Infrector: A completely filled in by the fu	Medical (hysician: To the best miner: On the basis and manner s	of examination a							
	To the within to the complex c	Me	29b. Signature and title of certifier				29c. Licens	e number		29d.	Date signed (Moni	th, Day, Year)
	/ 1		> Charles Rpile	m.0			02	4781		m	my At	2007
	(3)		30. Name and address of person who	completed cause of	Ive,	(Type, Print) #30			re p	13	2/20	29
Į.	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 9 2007	32. Regist	rar's Signature		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1137 200 Theresa Pollard Evelyn 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b-City, Town, or Location of Death Baltimure ta Paryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Year) 29 Days Hours Min th, Day, 1 □ M 2√2 F O MD 217-26-2677 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1403 Barrett Road 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Black 3 \ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Homemaker House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Johns Emily Dent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Barrett Road, Baltimore, Md 21207 Barbara Cooper-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/3/07 New Cathedral Baltimore, Md 21. Signature of Funeral Service Licent 22. Name and Address of Facility March F/H West 100 Wabash Ave, Baltimore, Md Me Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care on each line. Immediate Cause (Final disease or condition resulting in death) Embolism Ulmonary Due to (or as a consequence of): of the Abdomen wides cending Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ypertension Me to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 4 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** physician a the burial Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

the Medical I

Pages 1 and 2 should be filed wit trant of Health and Mental Hygien rtant: If item 27 is marked other th jury or other traumatic event, the

Department of Health ar Important: If item 27 is any Injury or other trauonce.

Director

Funeral

þ

Completed

Be (ပ

with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Be Completed Certification: To

27. Manner of Death

1 Natural

JUL

Hospital or Attending Physician: The law requires that the death certificate be executed aftending pl for use as t 24 hours after death. Ie Funeral Director; Apletely filled in by the fu

within 24 ho

To the Fun

completely the ం

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title MI 30. Nalme and address of person who completed cause of death (Item 23a) (Type, Print) MIS 31. Date filed (Month, Day, Year) 0 3 2007

28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30°, **Physician** 2007 10:02 A M Jennie May Parker June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year) Jan 25, 1946 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 61 222-28-9418 Washington Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Ceci1 Port Deposit Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21904 USA 2184 Tome Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any Injury or other traumatic event, the Megones. Elementary/Secondary (0-12) College (1-4or 5+) Law Office Paralegal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Coleman Lavina M. Pratt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Benjamin Parker, Husband 2184 Tome Highway Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 07/02/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Idensee
Thomas Gregor ^{22 Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11)eeks /Medical Due to (or as a consequence of): Examiner PNEUMONIA SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner STROKE The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician CEREBRAL ANEURYSM RUPTURED Physician/Medical the as for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Physician; 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation 1 ∏Yes 2 ∏No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Vital Records, P.O. Box 68760, or Attending Hospital

2

31. Date filed (Month, Day, Year) State Registrar

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

CMD

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Datę signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

555 W. Towsartown Blud/BaltonD 21204

3 0

32. Registrar's Signature

Certificate of Death

State Registrar 31. Date filed (Month, Day,

Year)

07-04 Kenn	916 eth C. Prale	v. 11	Please T	ype or Print in B State of Maryland	lack Ind	elible In	ı k. Ensu ı Health ar	re All Co	<mark>opies Are</mark> al Hygiene	Legible	e.	
TOTIL		· 	- For State			ficate of			2. Date o	Reg. No	e ! ***	3. Time of Death
Madi	Physicia ical Examir	_	1. Decedent's Name (First, M		. 7				Month	Day 25, 2007	Year	1920 hrs
indi.			4a. Facility Name (if not instit	C. Praley I tution, give street and number h Care System	<u>r)</u>	4	b. City, Town, o				c. County of Dea	eth .
	Funeral	4	Social Security Number		ge (In yrs. last	t birthday)	If Under 1 Ye	ar If Under	r 24Hrs. 8. Date	of Birth(MM	I/DD/YYYY) g. E	Birthplace (State or
	Director		214-50-1409	UES IN 2	58	Yrs.	Months Da	ys Hours	Min. Apı	<u>:i118</u>	,1949 G	Country) MD
	any	ŀ	Usual Residence of Deceden 10a. State 10b. Cour		10c. City, To	own or Locati	on					10d. Inside City Limits
	nd show a	۲	MD Bal	ltimore	E	Baltin	nore					1 Yes 2 X No
12	1715-0036 Id be filed within 72 hours after death with the Maryland had be filed within 72 hours after death with the Maryland narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	ock Avenue			10f. Zip Code 212(10g. Ci	tizen of What Co	ountry?
3	ith the 23a o notifi		11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Wa	L		in? (Specify Yes			erican Indian, Black,
9	eath w items ust be	Funeral	1 X Never Married 2	Married Armed Forces					Puerto Rican, et		White, etc.	
	fter de l", or ner m		3 Widowed 4	Divorced or Dates	Z NO	1	Yes 2X N	lo specify:			Specify:	White
	ours a	d by		Specify only highest grade co			t's Usual Occup ost of working li		kind of work done use retired)	16b.	Kind of Busines	s/Industry
	n 72 h n 72 h nan "n ical E	Completed	Elementary/Secondary (0- 12th	-12) College (1-4 o	r 5+)	•	air Met				BGE	
	5-0036 iled within 7 Hygiene. I other than the Medica	шо	17. Father's Name (First, Mic	ddle, Last)					's Name (First, M	ddle, Maide		
	215. be filed ntal Hy rked of	Be	Kenneth J.						a Ann I			
	2 2 2 2 1	To	19a. Informant's Name/Relat	tionship (Type, Print)		19b. Mailing	Address (Str	eet and Num	ber or Rural Rou	te Number,	City or Town, Sta	ate, Zip Code)
	and 2 shou fealth and N tem 27 is n traumatic	- 0		. Praley / f			Green		Road I	Balti	more M	D 21221
	of Hea		20a. Method of Disposition 1 X Burial 2 Crema	ation 3 Removal from S	State HOT	ematory or oti	per place) 1eemer	cemetery,	7/3/0		altimo	
	imC Page ment tant: or otl	П	4 Donation 5 Othe	er Specify:		_						
	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam.		21. Signature of Funeral Ser	vice Licensee								lto. MD
	Physician	1 11	23a. Part I. Enter the disease	e, or complications that cause	ed the death. I	Do not enter t	he mode of dyir	y Full ng, such as c	ardiac or respirat	ory arrest, s	hock, or heart	X 21221 Approximate Interval
1	/Medical	f W	failure. List only one ca	ause on each line.								Between Onset and Death
1	caminer		Immediate Cause (Final disc or condition resulting in deal				Carrons					
		L	Sequentially list conditions,	b.	annunca of							
		nine	if any, leading to immediate cause. Enter Underlying Ca	duse	isequence or							
A	ecuted and - transit	Examine	(Disease or injury that initiat events resulting in death) L		nsequence of)	:						
Ì	a a a	dical	X UNPENDED	X AMENDED # #23a,27,2	28a,perl 8a-f, pe	Æ,g8/0, erME,g87	8/24/0/ 0,8/14/0	TT)7 TT				
	ceath certificate be exeath certificate be exeatending physician for use as the burial	cian/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregn	ancy			c pregnancy	2	23d. Date of deli	very Day Year
	K 68 1 certi endin use as	iciar	past 12 months?	4 Pregnant	at time of dea		ther (Specify)					
	Boy e deatl the att ed for	Physi	1 Yes 2 No 9	J _ Officioni		-			220	Did tabaar	on una contributo	e to the cause of death?
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. To the Funerate Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	by	Part II. Other significant co	onditions contributing to de	eath but not re	sulting in the	underlying caus	se given in Pa				Probably 4 Unknown
	rds, requir been s	Completed							248	a. Was an autopsy		e autopsy findings available to completion of cause of
	eco ne law te has ige 2 s	dmc							1 🗸	performed Yes 2		າ? Yes 2 No
	nn: The		25. Was case referred to me				26.Pla		(Check only one)		
	n of Vital I ding Physician: 1. After this certif: i. funeral director,	o Be	examiner? 1 ✓ Yes 2 No			ER/Outpatien		Other ₄	Nursing Home			ther:
	I of ing Pl After funera	ı.	27. Manner of Death 1 Natural 5	28a. Date of I (Month, Da	Injury ay,Year)	28b. Time of	· · ·	njury at Worl	1 No.	escribe how	injury occurred	
	ivision or Attend after death. Director:	atic		Investigation 1/20/20	207 - 2006	unk		Yes 2 X	-	cation (Stree	at and Number of	r Rural Route Number, City
	Divis	Certification:		Could not be			eet, factory, offic	e building, e	or or	Town, State)	altimore, MD
	D Hospita 24 hours Funeral etely fille		29a. Certifier	ing Physician: To the best of	residend		rred at the time	e, date and pl				
181	To the Hosp within 24 ho To the Fune completely fi	edical	(Check only one) 2 Medical	Examiner: On the basis of e	examination ar	nd/or investiga	ation, in my opir	nion, death o	ccurred at the tim	e, date and	place, and due t	o the cause(s)
U	5 × 5 0	Me	29b. Signature and title of o	peptifier state			29c. Lic	ense number	7	29	d. Date signed	(Month, Day, Year)
			/ //	/			Ο.	C.M.E.		J	une 30, 2007	7
	OCME		30. Name and address of pe	erson who completed cause of D. Deputy Chief Me			1 Penn Stre	eet, Baltim	nore, MD 212	201		
		tate	31. Date filed (Month, Day,)	Year) 2007 32. Regis	strar's Signatu		and a					
	Regis	મારા	001	1	7	3						

Riley Pettus 07-04638 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1200			1	100	
fin.	i	10	à)

		- For State	Certific	cate of Death		Reg.	No	
Physicia		egistrar . Decedent's Name (First, Middle,Last)				2. Date of Death Month D	ay Year	3. Time of Death 1900 hrs
.l Exami≀		Riley Pettus	-daumhos)	Ab City Tow	m, or Location of Dea	June 17, 200	4c. County of Dea	ith
		a. Facility Name (if not institution, give street a 1300 block North Woodington Ro		Baltimo	re			
Funeral Director		5. Social Security Number	7. Age (In yrs. last bi			Irs. 8. Date of Birth(In. Dec 17,	1963 9. E	Sirthplace (State or sign unk Country)
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show any d at once.	اج	MD	Balti			11	0111	
Maryla 28a-f d at or	Director	10e. Street and Number		10f. Zip Co		109	. Citizen of What Co	ountry :
n with the Maryland ms 23a or 28a-f sho be notified at once.		310 E. Lanvale Stree	as Decedent Ever in U.S.		of Hispanic Origin? (Specify Yes or No-	USA 14. Race - Am	erican Indian, Black,
death wir	Funeral	1 Never Married 2 Married 1	med Forces? unk Yes 2 No	If Yes, specify	Cuban, Mexican, Pue	rto Rican, etc.)	White, etc	
after	by F	3 Widowed 4 Divorced If Yes, Cor Date 15. Decedent's Education (Specify only higher	S'	a Decedent's Usual Oc	No specify:		16b. Kind of Busines	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	during most of working	ng life. DO NOT use	retired) unk		unk
OO3	шо	unk unk 17. Father's Name (First, Middle, Last)		unk	18.Mother's Na	ame (First, Middle, Ma	aiden Surname)	unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	, , , , , , , , , , , , , , , , , , , ,						
ID 21: should be and Mer 7 is mar matic even	7	19a. Informant's Name/Relationship (Type, Pri O • C • M • E •	nt)	19b. Mailing Address 111 Penn S				ate, Zip Code)
∑ 297		20a. Method of Disposition		ce of Disposition (Name matory or other place)		Date	20c. Location - City	or Town, State
nore		1 Burial 2 Cremation 3 Rer 4 Dopation 5 Other Specify: 17	noval from State					
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		21. Signature of Funeral Service Licensee Ronald Sawad		State Ar	address of Facility	rd 655 W.	Baltimor	e Street
	-	23a. Part I. Enter the disease, or complication		ID a 1 + imax	- MD 212	Ω I		Approximate Interval
nysician /Medical		failure. List only one cause on each line	ole Gunshot Wounds					Between Onset and Death
Examiner		Illimodiate edate ((or as a consequence of):					
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):					
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):					
cuted and transit	Ш	events resulting in death) Last d.	(or as a consequence or).					
	1 17	UNPENDED	NDED					
6 5 g		IF FEMALE: 23c 23b. Was decedent pregnant in the	. If yes, outcome of pregnar Live birth	ncy 2 Fetal death	3 Ectopic pr	egnancy	23d. Date of del Month	ivery Day Year
n of Vital Records, P.O. Box 687 dding Physician: The law requires that the death certifical. After this certificate has been signed by the attending p. c. functal director, page 2 should be detached for use as th	sician/	past 12 months?	Pregnant at time of death					
Boyne death	Phys	Part II. Other significant conditions contri	Unknown	ulting in the underlying	cause given in Part I	. 23e. Did to	bacco use contribu	te to the cause of death?
P.O. ires that the signed by	<u>`</u>	Part II. Other significant conditions	butting to doctor between			1 Yes	2 V No 3	Probably 4 Unknown
ords, w require is been sign should by	ompleted					24a. Was autop	sy prio	re autopsy findings available r to completion of cause of
e law re has be ge 2 sh	Ta La					perfo 1 ✓ Yes	rmed? dea 2 No 1	th? Yes 2 No
Vital Recysician: The lability certificate by director, page	ပိ	25. Was case referred to medical		2	26.Place of Death (Cl			
Vita hysicia this co	To B	examiner? 1 ✓ Yes 2 No	I Inpatient 2		OA Other ₄ N		Residence 6	Other: Scene
n of ding Ph		1 Natural 5 Pending	FOUND:	FOUND:	1 Yes 2 N	Subject sho		
Sio Viter deat deat	ertification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom		, office building, etc.	an Tarres (24-4-1	or Rural Route Number, Cit odington Road, Baltimor
Divis To the Hospital or A within 24 hours after To the Funeral Director of t	၂ပ	4 Memicide	(Specify) (Found) Wo	doath occurred at the	e time, date and place	and due to the cau	se(s) and manner as	s stated.
ithin 2-	Medical	one) 2 Medical Examiner:On the	he basis of examination and manner stated.	d/or investigation, in my	y opinion, death occu	rred at the time, date	and place, and due	(Month, Day, Year)
) §	29b. Signature and title of certifier		290	o.C.M.E.		June 18, 200	
		Curab C		220)	J.O.IVI.L.		15.10 .0, 200	
		30. Name and address of person who compl Ana Rubio MD. Assistant M	eted cause of death (Item 2 edical Examiner 1	^{23a)} 11 Penn Street, E	Baltimore, MD 2	1201		
	Stat	31. Date filed (Month, Day, Year)	32. gistrar's Signature					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,7

		For State	State of	Marylan		artment of H		nental Hyg	jiene		
		Registrar	14		Cei	rtificate of L	Jeatn 	2. Date of Dea	leg. No.	<u> </u>	3. Time of Death
Physicia /Medic	ın	1. Decedent's Name (First, Middle, William	Last)	P1un	kert			Month June		2007 ear	2:13am M
Examin		4a. Facility Name (If not institution,		ber)			Location of Death			nty of Death	1
400円 <mark>ユー・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・</mark>		6362 Sykesville 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birth	1		place (State or Foreign
Funeral Director		215-48-7433	1 M 2 □ F	54	Yrs.	Months Days	Hours Min.	(Month, Day Aug. 7	, Year) 1952	Cou	ntry) MD
D >		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
laryla shov ed at	ř		roll	100.010	y, rown or Lo	Sykesv	ille				1 ☐ Yes ¾☐ No
the M	Director	10e. Street and Number				10f. Zip Code			10a. Citizen	of What Cou	ntry?
3a or		6362 Sykesvill	e Road				21784			USA	
death	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	necify Yes or No-	14. F	Race - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 【 Marrie 3 ☐ Widowed 4 ☐ Divorced		² XNo		1 □ Yes 2 🎇 No	Specify:	Tribari, etc.)			nite
72 hou natura dica! E	eted	15. Decedent's	s Education grade completed)		i (Give	dent's Usual Occupa	lurina most of work	king	16b. Kind o	f Business/In	dustry
within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	DO NOT use retired Carpente:			Const	ructio	on
ifiled I Hygi other ent, t	Be C	17. Father's Name (First, Middle, L	ast)			January	18. Mother's Nam	e (First, Middle,			
uld be Venta rrked tic ev	ToB	Warren Plunke	rt				Agnes	Irene M	iller		
2 sho and I Is ma		19a. Informant's Name/Relationshi Mrs. Charlene K	p (Type. Print)	Spouse)) 19b. Mailir	ng Address (Street a					•
land lealth im 27 ther tr		20a. Method of Disposition	ay I Lunke.	206 5	6362	Sykesvill sition (Name of		Sykesvil.	·	21784 on - City or T	
ages intof h		1 X Burial 2 ☐ Cremation		itate c	cemetery, crei	natory or other place	e) ¦			,	•
mit. P. sartme sortani		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		4			1			ville,	
Per Der		> Grean L	. Haigh	+	I H S	AIGHT FUN Name and Addres AIGHT FUN ykesville	MD 217	84 (410)	-795-	i 400 (b	OX 193)
Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on e	or as a conseq	G Ca	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	i,	Approximate Interval Between onset and Death
cate be executed only sician and the burial-transit	al Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq							
tificate ng phys as the	edical		d								
To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2□Feta ant at time of d	al death 3[⊒Ectopic pregnancy]Other <i>(sp</i> ec <i>ify)</i>			23d.	Date of deliv Month	ery Day Year
es that igned b	ρ	Part II. the r significant condition	ns co, tributi - to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.	V/			the cause of death?
requi	sted	J Backer III	Dillion Dillion	4-1				1 A Y		3000	
The law ate has b	Completed							24a. Was autop perfoi 1□ Yes	sv	lb. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
clan; ertifica	Be	25. Was case referred to medical examiner?					26. Place of Dear		ne)		
Physic this cal	2	1 ☐ Yes 2 No			ER/Outpatier		4 🗆 Nursing H			Other (Speci	fy)
ding F J. After funer	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	,	n, Day Year)	28b. Time o Injury	Worf	yat (? Yes 2∐No	28d. Describe h	ow injury oc	curred	
To the Hospital or Attend within 24 hours after death. To the Funeral Director; /	Certification:	2 Accident Investigs 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of injury - At hog, etc. <i>(Specit</i>	ome, farm, str fy)	reet, factory, office	.00 2	28f. Location (S City or Tow		ımber or Rur	al Route Number,
n 24 hour n 24 hour he Funer	edical (29a. Certifier (Check only one)	Physician: To the xaminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and date and pla	manner as s ce, and due	stated. to the cause(s)
To the transfer of the transfe	¥	29b. Signature and title of certifier	1.41.1	J.M.) ,	29c. License	05491		29d. Date sig	ined (Month)	Day, Year)
5		KOOKIGO B	ho completed cause	al	TUL	Print), SELV	EXENE 1	Ave. B	a Hiv	WIF	MD212L
Sta Registr		31 Date filed (Month, Ody, Year)	2007	egistrar's Signa	the A	role					
HMH 17 Rev 1/20	n1	30 T 0	-	40-				-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar				Cei	rtificate d	of D	eath			Reg. No.	2 11	-7	0197	1
	Diam'r.		1. Decedent's Name (First, Middle, La	st)							2. Date of De	eath Day	Ye	ar.	3. Time of Death	
	Physici /Medic		Kathryn		Ward	Pá	ayne					June	30,	2007	ai	12:10A ^M	1
	Examin		4a. Facility Name (If n	_				4b. City, Tow			f Death			County of D			
		.2	831 Ritch					Severn			3411m		1	ne Ar			
ū	Funeral Director		5. Social Security Num 217-16-44 Usual Residence of D	78	ex 7. Age	e (In yrs. last t	Yrs.			Hours	Min.	8. Date of Bir (Month, Da Sept.	24, 19	9.	Birthpl Count	ace (State or Foreigr ry) MD	7
	land ow It			Ob. County		10c. City, To	wn or Lo	cation							10	d. Inside City Limits	
	Mary fied a	to	MD	Anne Art	ınde1	Severr	na Pa	ark								1 □Yes 2🌠 No	,
	n the	Funeral Director	10e. Street and Numb	per				10f. Zip Cod	de				10g. Citiz	zen of What	Coun	ry?	
	th wit	a	831 Ritchi	e Hwy.	#408			21146)				U.	S.A.			
	ems er m	ine	11. Marital Status		12. Was Decedent 8 Armed Forces?		13.	Was Decedent If Yes, specify	of Hisp Cuban,	panic Orig , Mexican	gin? (Spec	cify Yes or No Rican, etc.))- 1	14. Race - A Black, W			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		1□Yes 2【X)						Specify:	Whi	te	
8	2 hou	be	1	5. Decedent's Ed	l ducation	16	a. Dece	dent's Usual O	ccupati	ion			16b. Kir	nd of Busine	ss/Ind	ustry	-
215	hin 72 3. an "na Mech	Completed	(Specify Elementary/Second	only highest gra	de completed) College (1-4or 5	+)	(Give life. l	kind of work do DO NOT use re	one du etired)	ring most	of workin	g	Anne	Aruno	de1	County	
2	yd wit	5			4		Teac	her						Pub	lic	Schools	
p	be file	Be (17. Father's Name (Fi)				1			(First, Middle	, Maiden	Surname)			
yla	Men arke	မ	Edward Joh								ice R						
Nar	12 sh h and 7 is m raum		19a. Informant's Nam Mr. Louis	, ,	** /			ng Address (St									
e,	1 and Healt em 2: ther		20a. Method of Dispos		ne/ nusband			sition (Name o				severn		cation - City		and 21146	
Baltimore, Maryland 21215-0036	ages ant of t: If it y or o			Cremation 3 □	Removal from State	1		natory or other ark Cem		,	July 2007	3,					
	nit. Partme		1. Signature of Fund			Loude		2. Name and A		of Facility	2007 Sino	leton	Funo	imore	, M	aryland	-
B	Dep Imp any		1	oll	00	1364	1	Second	d Av	venue	SW	Glen B	urni	e, MD	21	, F.A. 061	
			23a. Part1. Enter the	disease, or com	plications that caused one cause on each lir	the death. Do	not ent	er the mode of	dying,	such as	cardiac or	respiratory a	rrest,		Ti.	Approximate Interval Between	E.
	Physician	1/1	Immediate Cause (Findisease or condition		20	-evin	-11	a	AS	Carri	e fre	~			1	Onset and Death	
1	/Medical		resulting in death)		Due to (or as	a consequenc	e of):	4	,			red			+	7 100001 -1	_
6	Examiner		Sequentially list cond	itions.	b. 4/-	Leini	ers	٦ -	-	Ad	var	red				10 year	1
1	ed sit	ine	Sequentially list cond it any, leading to limit cause. Enter Underly Cause (Disease or inj	ring	Due to (or as	a SuriSequerio	6 UI).										
L	and and Il-tran	Examiner	that initiated events resulting in death) Las		c Due to (or as	a consequenc	e of):								+		_
68760,	certificate be executed ding physician and ise as the burial-transit			l	d												
289	ificate g phy.	Medical			d												
Box	h cert		IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy	th of	Testa pia puaga					2	3d. Date of	delive	у	
B	w requires that the death ce been signed by the attendi should be detached for use	Physician/	in the past 12 m 1 □ Yes 2 ☑ 1		4☐Pregnant at			∃Ectopic pregn ∃Other <i>(specif</i>						Month		Day Year	
P.O.	The law requires that the steep size has been signed by the sage 2 should be detache	Phy	9 Unknown			441						00. 5:11				() 0	
	res th	by	Part II. Other signification	ant conditions of	ontributing to death bi	it not resulting	in the u	nderlying cause	e given	ıın Part I.		23e. Did 1		/		e cause of death? ably 4 □Unknown	
9	requi	eted		400								-	163 24				
3ec	as 2	Completed										24a. Was		24b. Were	to con	esy findings available apletion of cause of	è
a	n: Th ficate r, pag		05.00									1□ Yes	2 □ No	1 0	es_	2 No	
₹	Physician: r this certific ral director,	Be C	25. Was case referred examiner?		Hospital:	-t 2000)t	it 3□ DOA	Other:			(Check only o					—
ō	Phy er this eral d	٦. ح	27. Manner of Death		28a. Date of Inju	nt 2 ☐ ER/0	. Time of		Injury a Work?	4 🗆 Nui	<u> </u>	ne 54 Resi 8d. Describe			Specify)	
on	Attending r death. ector: After by the fune	tiol	1.☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day	Year)	Injury			es 2 🗆 N	No .						
Division or Vital Records,	Atte	ific		6 Could not be determined	28e. Place of inju	ry - At home,	farm, str	eet, factory, of	fice		2	8f. Location (Rurai	Route Number,	=
	ital or rs afte al Dir ed in	Certification:			1	(mi, olate)				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1, (Check only 2 one) 2	✓ Certifying Ph ☐ Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination a	ge, deat and/or in	h occurred at th	ne time my opii	e, date and inion, dea	d place, a th occurre	nd due to the ed at the time	cause(s) , date and	and manne place, and	r as st due to	ated. the cause(s)	
	o the	Mec	29b. Signature and tit	le of certifier	and mariner sta	ited.	_	29c. Lic	cense r	number			29d. Date	e signed (M	onth, I	Day, Year)	
	->-0) (()	20	100	-10		14	4-	774	V		7	12/0	07		
,	6		30. Name and addres	s of person who	completed cause of d	eath (Item 23a) (Type,	Print) D.	. 8	401	O A.	- 501	twit,	12/0	۵	. 0.	_
	ン		203	Horper	tal Bri	J.P	, 6	65,0	ايما	(>	10	61	57	€ 3.	22		
	Sta Registr		31. Date filed (Month,	Day, Year)	32. Registra	ar's Signature	B	e4 -									
	negisti	aı	10	L N 9 COI	FOR NEWS	J.	400	W.									

			1 - State Amend #19a per 1	tate of Maryland FH G869 7/05	707_CT	rtment of H	lealth and N Death	vientai Hy	giene, Reg. No.	2007	21371
	Dhyaisi	.	Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Clara	В.	Phill:			6	28	2007	10:28a M
	Examin	er	4a. Facility Name (If not institution, give street				Location of Death	1	4c. (County of Dea	th
	***		Joseph Richey Hos 5. Social Security Number 6. Sex	7. Age (In yrs. li	ast birthdav)	Balti If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	NA 9. Bir	thplace (State or Foreign
	Funeral Director		045-30-6039 ^{1□ M}		Yrs.	Months Days	Hours Min.	(Month, Di	ay, Year) -1939		N.C.
	ъ		Usual Residence of Decedent	140-07	-						Lord to the first to
	arylar show d at	_	10a, State 10b, County	10c. City	, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
	he Mi 28a-f	Director	Md. NA		pal	10f. Zip Code			10a Citis	zen of What C	
	with ya or 3	Dir	1817 N. Washingto	n Street		212	713		rog. Oiliz	USA	outhly.
	death ms 2:	Funeral	11 Marital Status 12. V	Was Decedent Ever in U.S	S. 13. V		ispanic Origin? (Span, Mexican, Puerto	pecify Yes or N	0- 1	14. Race - Ame	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the Az is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Married	Armed Forces? 1		Yes XX No	Specify:	o Rican, etc.)		Black, Whi	te, etc. lack
21215-0036	2 hou atura	ted	15. Decedent's Education	on	16a. Deced	ent's Usual Occup	ation		16b. Kir	nd of Business	/Industry
215	thin 7, e. an "n Medi	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retired	during most of word f)	king			
	ed wil ygien ier th	9	12th grade		Lal	orer				ler Lau	ndry
ביים	be fill htal H ed oth	Be	17. Father's Name (First, Middle, Last) Noah	Mourning			18. Mother's Nam	ne (First, Middle		Surname) Blount	
Maryland	hould d Mer narke natic	은			19h Mailin	n Address (Street	and Number or Ru	ural Route Numi			Zin Code)
2	nd 2 s Ith an 27 is		19a. Informant's Namphakationship Type. I	Husband	i		ington S				
q	s 1 ar f Hea f Hea other	-	20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date		cation - City or	
5	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	ovar irom State	t. Zio		7-5	-07	Lar	nsdowne	, Md.
Baltimore	rmit. sparth porta y Inju		21. Signature of Funeral Service Licensee			Name and Addre		March F			,
(I)	9 2 E % 9		- Tradition				North Ave			e, Md.	21202
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cannot be a second shock of the second s	ons that caused the death ause on each line.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	metaslatic		on canc	er				unknown
	Examiner			Due to (or as a consequ	ence of):						
200		Jer	Sequentially list conditions, lib.	Due to (or as a conse	uence of						
0	icate be executed physician and sthe burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
	oe exe cian a	EX	resulting in death) Last	Due to (or as a consequ	ience of):						
(7.7) 68760	ficate be physicia s the bur	edical	d								
3		//Me		If yes, outcome pf pregna					2	23d. Date of de	eliverv
<u>~</u>	death certi e attending d for use a	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify) _	1			Month	Day Year
90	at the by the tached	hys	9 □ Unknown	9□ Unknown							
() "	gned gned	by F	Part II. Other significant conditions contrib	uting to death but not resu	ılting in the ur	derlying cause giv	en in Part I.			/	to the cause of death?
. 2	requi							1	Yes 2[Probably 4 🗍 Unknown
3	2 38 2	Completed						24a. Was	s an opsy formęd?/	24b. Were a prior to death?	completion of cause of
2	ysician: The is certificate hadirector, page		25. Was case referred to medical					1☐ Yes	2 N o	1 ☐ Ye	s 2 DVNo
5	sicial certi	o Be	examiner? 1 Yes 2 No	oital: 1 □ Inpatient 2 □ I	EB/Outnatien	t 3 DOA Oth	er:	ith <i>(Check only</i> Iome 5□Res		S HOthar (Sa	miltospice.
35	ding Phys	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe			ecity 03 proce
	ath. or: After	atio	1 Natural 5 Pending investigation	(MOHIII, Day Teal)	пдагу		Yes 2 □ No				
	or Atte ter de Irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 2	8e. Place of injury - At ho building, etc. (Specify		eet, factory, office		28f. Location City or To	(Street and wn, State,	d Number or F)	Rural Route Number,
_	urs af			T. II. 1							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	an: To the best of my know On the basis of examination and manner stated.	tion and/or in	estigation, in my	ppinion, death occu	rred at the time	e, date and	and manner a I place, and du	e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c, Licens	e number		29d. Dat	e signed (Mor	nth, Day, Year)
			> 2150 M	>		D-	24170		Ju	ne 28	, 2007
	3		30. Name and address of person who compl	eted cause of death (Item	23a) (Type,	Print)	Eut	St R.	16.		10 21201
	Str	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	J JO 1VI	cman	/1 (30	LITIM	wrep	1 21 201
	Regist		JUL 0 3 2007	Belguas B	Los	de					

Patient Known as Robert PlotKin Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

	For State of		artment of Health	and Mental Hy	giene	
	Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	2. Date of De		3. Time of Death
ian ical	ROBERT		PLOTKIN	Jone	30 200	7 2035 "
er	4a. Facility Name (If not institution, give street and num	of Bultim	4b. City, Town, or Location of	TIMORE	4c. County of De	
	5. Social Security Number 116-18-8473 6. Sex 1 M 2 D F	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bir Min. (Month, Da 06/20/	rth 9. E	Birthplace (State or Foreign Country)
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation	- 00/ 40/		10d. Inside City Limits
ctor	MD BALTIMORE	RAN	DALLSTOWN			1 □Yes 2 □No
Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What	•
Funeral	9027 SAMOSET ROAD 11. Marital Status 12. Was Deced	lent Ever in U.S. 13.	21133 Was Decedent of Hispanic Ori	gin? (Specify Yes or No	U.S.A.	merican Indian,
2	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes. 2 If Yes, Give Year or Dat	P X No	If Yes, specify Cuban, Mexican 1 ☐ Yes 2 No Specify:	ĭ, Puèrto Rićan, etc.)	Black, Wi	hite, etc. WHITE
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-2)	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired) SMAN	t of working	VAN DYKE	& BACON SHO
Be	17. Father's Name (First, Middle, Last)		18. Mothe	r's Name (First, Middle	•	
0	PHILIP 19a. Informant's Name/Relationship (Type. Print)	PLOTI 19b. Maili	KIN SARA ng Address (Street and Number	er or Rural Route Numb		IERTOK Zip Code)
	JACQUELINE PLOTKIN/WIFE	9027	SAMOSET ROAD			*
	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)		matory or other place)	7/02/2007	BALTIMORE,	
	21. Signature of Funeral Service Licensee		2. Name and Address of Facilit 8900 REISTERS	JOL LLY	/INSON & BR - PIKESVIL	
dical Examiner	Sequentially list conditions, b. District (cause. Enter Underlying Cause (Disease or injury that initiated events extended to the cause (Disease or injury).	r as a consequence of): r as a consequence of): r as a consequence of):	atory am	est		Onset and Death 12 hours
Pnysician/Med	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of d	delivery Day Year
2	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in Part I.	23e. Did t		to the cause of death?
completed		198 //	21/119/13/7	24a. Was	an 24b. Were	autopsy findings available o completion of cause of
Be Co	25. Was case referred to medical		26 Place		2 No 1 □ Ye	
e L	27. Manner of Death Natural 5 Pending (Month,	patient 2 ER/Outpatier Injury 28b. Time o Injury	ot 3 DOA Other: 4 Number Numbe	rsing Home 5 Resi		pecify)
Cel IIII Calloli.	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place o	f injury - At home, farm, str g, etc. <i>(Specify)</i>	M		Street and Number or wn, State)	Rural Route Number,
Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and mann	is of examination and/or in	h occurred at the time, date and vestigation, in my opinion, dear	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
	MILLER		Res O	20	June 30	02007
	30. Name and address of person who completed cause	9, MD	Print) SMAL HO	pital o	1 Bas	0 2007 Vinone
ate rar	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	Coasts?			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-04970

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christopher Michael	1- For State	State	of Maryla	nd / Depa <i>Cer</i> i	rtment of tificate of		nd Ment	tal Hyg		eg. No.	200	7 2 3
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) stopher		l Peters	son				Date of Deat Month June 29, 2	th Day	Year	3. Time of Death 2002 hrs
C	4a. Facility Name (if n 6962 Pindell S	ot institution, give				b. City, Town, o	or Location o		1944		nty of Death rd	<u></u>
Funeral Director	5. Social Security Num 216-90-86		M 2 F	7. Age (In yrs. la		If Under 1 Ye Months Da				th(MM/DD/Y)	Foreig	thplace (State or In Washington untry) D.C.
land -f show any once,	Maryland	b. County Howard		10c. City,	Town or Locati Fult	on						10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Numb		ol Road	d		10f. Zip Code 207	59		1	0g. Citizen of U.S.		ntry?
r death wi	11. Marital Status 1 XNever Married 3 Widowed	4 Divorced	Armed For 1 Yes If Yes, Give Year or Dates:	2 X No	1	s Decedent of Hes, specify Cuba	an, Mexican,	, Puerto Ri	ican, etc.)	Speci	hite, etc.	ican Indian, Black, nite
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner Completed by	15. Decedent's Educ Elementary/Second 12	lary (0-12)	y highest grade College (1-			t's Usual Occup ost of working lit Lician	e. DO NOT	use retired	d)	_	A-Loc	
ID 21215-003 should be filed with and Menal Hygiene and Menal Hygiene 77 is marked other til natic event, the Mer To Be Com	17. Father's Name (Fi Michael 19a. Informant's Name	Peterso			19b. Mailing	Address (Stre	Fa	aye H		_		e, Zip Code)
of H	Michael F 20a. Method of Dispos 1 X Burial 2	cremation 3	(Fathe	m State 20b. F	Place of Dispos crematory or oth		emetery,	1	Date	20c. Locati	on - City or	Town, State
	21. Signature of Fune	L. Hade	ma	UDIOS	D 22.10 Wi 55	Memoria lame and Addre tzke Fu 55 Twin	ss of Facility neral Knol	Home 1s Ro	sad Inc	lumbia	, MD	e, MD 21045
Physician /Medical xaminer	23a. Part I. Enter the of failure. List only Immediate Cause (Fir or condition resulting	one cause on eac nal disease a	Narcotic	intoxica consequence of	ation	ne mode or dyini	g, such as ca	ardiac or r	espiratory arr	est, snock, or	near(Approximate Interval Between Onset and Death
cecuted - transit	Sequentially list condificant, leading to immocause. Enter Underly (Disease or injury that events resulting in december 1997)	ediate Dring Cause t initiated C.		consequence of								i
be expectation of the control of the	IF FEMALE: 23b. Was decedent prepast 12 months?		1 Live bir	ant at time of dea	ancy 2 Fe	7/27/07 tal death 3 her (Specify)		c pregnanc	cy	23d. Date Mont	e of deliver	y Day Year
rds, P.O. Box 68: requires that the death certification been signed by the attending hould be detached for use as the letted by Physician!	Part II. Other signific			death but not re	esulting in the u	nderlying cause	given in Pa	art I.	-	-	_	the cause of death?
tal Records, ician: The law require. recrificate has been signeter, page 2 should be Be Completed					·			_	24a. Was autop perfo 1 Yes	rmed?		utopsy findings available completion of cause of es 2 No
n of Vital ling Physician: After this certifuneral director	27. Manner of Death 1 Natural 2 Accident	Ho	28a. Date of (Month,		ER/Outpatient 28b. Time of li FNd 7:53 ome, farm, stree	3 DOA njury 28c. In 1 Dm	Other ₄ Jury at Work Yes 2 X	Nursing 2	Home 5 8d. Describe unk	Street and Nu	curred	r: Scene ural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide 29a. Certifier (Check only 1 Ce	determined ertifying Physicia edical Examiner:	(Specify) in: To the best On the basis of	of my knowledg f examination ar				ace, and di	ue to the caus	iell Sch se(s) and mar	ner as stat	
Te W.W.	29b. Signature and titl	e of certifier The	and manner sta	L			ose number			29d. Date s June 30		nth, Day, Year)
State	30. Name and address Margarita Kor 31. Date filed (Month.	ell MD. Ass	sistant Med	ical Examin	er 111 P	enn Street, I	Baltimore	e, MD 21	1201			
Registrar DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) 31. Registrar's Signature ORIGINAL											

DHMH 17 Rev 1/2001 OCME 2006

00115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend 26,29d, per MD, g869 7/3/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner avern 9. Birthplace (State or Foreign Gountry)

Vew York Date of Birth (Month, Day, Year 5. Social Security Number **Funeral** Months 1 M 2 M -31 Director Usual Residence of Decedent 10c. City, Town or Location 0d. Inside City Limits a or 28a-f show t be notifled at 10a. State 10b. County 1 **T**es 2 □ No Director MD HMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r Items 23a o Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Completed by Funeral 4. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Item edical Examiner r 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced er than "nature , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Item 27 Mother other 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate
Interval Between
Onset and Death

Months 23a. Part1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform r this certificate h death? 1 ☐ Yes 2□No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Brother's Home Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 4 ☐ Nursing Home 5XP ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death I Director: After t d in by the funera Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, 32. State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

amend item 6 provests 27-307 yrt of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 22 Raheem 2007 Beatrice Valerie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baint Healthcare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) Months 1 □ M 2 🛛 F 50 213-62-7370 56 MD 10 08 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at Y Yes 2 No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a o 21229 U.S.A. 570 Brisbane Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married No ive Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Genesis Health Care Staffing Coordinator <u>12th grade</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Beatrice Toyer Julius Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 570 Brisbane Road, Baltimore, Md Hakim Raheem-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State 4 □Popation 5 □ Other (Specify) King Memorial Park 6/26/2007 Randallstown, Md 22 Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Sigr atur df Funeral Service Licensee 21215 Baltimore, 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart leture. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** ancreation Ven. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardiopulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and ched for use as the burial-transit The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2□No 1 ☐ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 | Yes 2 | No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient →9☐ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this, completely filled in by the funeral dii 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Gaan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760,

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed cate has been signed by the page 2 should be detached filled in by the within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai

Physician

Pages 1

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	in 9		AVOR YIVE S OY
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy er (specify)		23d. Date of delivery Month Day Year
0 1	tributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Cor l'ula	unale		1 (es	2 No 3 Probably 4 Unknown
Ischemic Congestion	Cerdiomyopa re Heart Fa	Thy I lure	24a. Was an autopsy performed	
25. Was case referred to medical examiner?			th (Check only one)	
1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing H	lome 5 Residence	e 6 □Other (Specify)
27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of injury M	28c. Injury at Work?	28d. Describe how i	injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	sician: To the best of my knowledge, death occu ner: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier		29c. License number	29d.	Dete signed (Month, Day, Year)
1 Sult	MD	D003762	4	6/29/2007
	mpleted cause of death (Item 23a) (Type, Print) The state of the stat	oesler Rd.	(. 100 B	urnie 21060
VU OVIN SEPTE	20 Posistrodo Signoturo	1	014712	

State

Registrar

31. Date filed (Month, Day, Year)

0 3 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _ Month Year Kider 3:45 PM 2007 Henry July 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Northwest Hospital Center andal own 8. Date of Birth (Month, Day, Feb 12 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign WV Country) 192<u>8</u> Days Min 1 TM 2 F Months Hours 79 236-40-2511 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Eldersburg Carrol1 1 ☐ Yes 2 No 10g. Citizen of What Country?
USA 10e. Street and Number 10f. Zip Code 5317 Wendy Road 21784 12. Was Decedent Ever in U.S. Armed Forces? 1♥JYes 2□No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) wallpaper hanger/carpenter construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Alice Price Henry David Rider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel W. Rider (spouse) 5317 Wendy Rd., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 7-2-07 |Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses ▶ Pagespaight o ervers P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jelerium Due to (or as a consequence of): system dysfunction Due to (or ab a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last stemic intlammatory response Due to (or as a consequence of): piration oneumonia IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown disease Alzheimer demention pulmonary 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No disease autopsy performed! Yes 2 No disease f Death (Check only one) Periphera Cerebrovascular disease arkria 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July

Randallstown

29d. Date signed (Month, Day, Year)

200

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

à

Completed

Be

2

MD

Funeral

Director

show

Item 27 Is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified.

72 hours after

s 1 and 2 should be filed within 7 If Health and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and for use as the burial-tran the as signed by the a

Box 68760,

page

Physician/Medical

Completed by

Be

Medical Certification: To

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and, title of certifier

J Boston

31. Date filed (Month, Day,

6 Could not be determined

Year)

0

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

2007

Northwest

32 Registrar's Signatore

5 Ceps

certificate has funeral director After this

Division or Vital Records, P.O. Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

State

Registrar

DHMH 17 Rev 1/2001

Hospita

1 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28462

Center

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

,ciai		1 - For Amend 10d, per Registrar 1. Decedent's Name (First, Middle, Las.			-	tificate		_		2. Date of D	Reg. No. eath Day		3. Time of Death
ysicia Iedic		Asako Reth								07/01/	2007	, Teal	3:00am M
amine	er	4a. Facility Name (If not institution, give						Location o	f Death		4c.	County of Dea	th
		63 Prospect Bay Dr		//		Grasor		le If Under:	Od Hee			een Ann	
eral ctor		5. Social Security Number 6. Se 212-36-0364	M 2 X) F 7. Age	75	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 03/03/		_[_C	thplace (State or Foreig ountry) uria, China
=		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
Bell	ģ	MD Baltimore		Arbut	us								+ XX 2 1 No
90	Š	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	ountry?
	ē	1123 Regina Drive				2122	27					USA	
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Vas Decede Yes, speci □ Yes 2	fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		14. Race - Ame Black, Whit SpecifyOri	e, etc.
E 103		15. Decedent's Edu	ucation		16a. Deced	ent's Usual	Occupa	tion				nd of Business	
De Misse	Completed	(Specify only highest grad	de completed) College (1-4or 5		(Give	kind of worl OO NOT use	done de retired)	uring most	of worki	ing		tinghou	
	0	17. Father's Name (First, Middle, Last)			riccour	icing			r's Name	(First, Middle			se
	0 8	Nisaburo Tanaka					D	Mine	Itoh	1			
		19a. Informant's Name/Relationship (T)	ype, Print)								-	r Town, State, 2	
		Alan Reth / Son								Taraba de	rasor	nville,	MD 21638
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		L .	ice of Dispo netery, cren O Crer	natory	7	0	7/03	6/2007	Cator	cation - City or nsville	, MD
any injury or other		21. Signature of Funeral Service Licens	RP I	MO137	8 72	Name and ary L. 250 Wa	Address Kau Ashir	of Facility LEMan ngton	Fun Blv	eral H	ome a krido	at MMP, ge, MD	INC. 21075
	icai Examiner	23a. Part. Enter the disease, or conditations shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each iin	A ST a conseque	ATI Conce of):					ANCE			Interval Between Onset and Death A YEAR:S
-	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at	2 □Fetal d	eath 3 🗆	Ectopic pre					2	23d. Date of del Month	ivery Day Year
	by Phys	9 ☐ Unknown Part II. Other significant conditions co	9□ Unknown ntributing to death bu	t not result	ing in the ur	derlying ca	use giver	n in Part I.		23e. Did	tobacco u	se contribute to	the cause of death?
										×	Yes 2[□No 3□Pr	obabiy 4 ∐Unknown
2000	Completed								_	24a. Whas auto perfo		prior to death?	itopsy findings available completion of cause of
5	90	25. Was case referred to medical examiner?						26. Place	of Death	Check only	-/-	- 103	2010
	2	1 □ Yes 2 No	Hospital: 1 ☐ Inpatier		P/Outpatient	3□ DOA	Other	4 □ Nur	sing Hor	ne 5 ☐ Resi	dence 6	Other (Spec	s residenc
	Ceruication	27. Manner of Death 1	28a. Date of Injun (Month, Day	Year) 2	8b. Time of Injury	M 28	c. Injury a Work?	at es 2 □ N		28d. Describe	how injury	occurred	
		4 Homicide determined	28e. Place of Inju building, etc.	(Specify)						City or To	wn, State)		iral Route Number,
	Medical	29a. Certifier (Check only one) Certifying Phy Dedical Exami	sician: To the best o ner: On the basis of and manner stat	f my knowle examination ed.	edge, death n and/or inv	occurred at estigation, i	t the time n my opii	, date and nion, deat	f place, a h occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	2	29b. Signature and title of certifier	e MD			_	License	number	4		29d. Date	signed (Monti	n, Day, Year)
. 1	- 5												

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2007 Physician 28, June 11:30A^M Edward James Roberts /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkridge 6767 Washington Boulevard Howard ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 91 1**X** M 2□F Yrs. 220-09-6839 Director 3/16/1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 👿 No Elkridge Maryland Howard Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6767 Washington Blvd. 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify:White δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph C. Roberts Bernadette Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6767 Washington Blvd., Elkridge, MD 21075 James E. Roberts/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriaf 2 ☐ Cremation 3 ☐ Removal from State Mt.Olivet Cemetery 7/2/2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. MD, 21075 Inc. 7250 Washington Blvd., Elkridge, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death My ta Static Immediate Cause (Final (une (ancino ma **Physician** disease or condition resulting in death) /Medical Examiner (as cinoma Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Tres sclevote Cordiovarcular Dipease To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 Other (specify) ed by the a s been signed be should be deta Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has to page 2 s certificate 1□ Yes 2□No 25. Was case referred to medicat Be 26. Place of Death (Check only one) examiner? Other: ۵ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) SE 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 30641 Vaus 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Rover Neck Road Hallman Mayland Kamesh Sala palas 201-109 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

0 3 2007

JUL

Please	Type or	Print	in	Black	Indelible	lnk.	Ensure	All	Copies	Are I	Legible.
	-						4.4				

_		For State Registrar	State of I	Maryland	_	artment <i>rtificate</i>					Reg. No.		015	
Physicia	-	Decedent's Name (First, Middle, Edward	Last)		Sr	oka				2. Date of De Month June		20077	3. Time of 4:15	
/Medic Examin	_	4a. Facility Name (If not institution,		er)		4b. City, To	own, or L	ocation o			4c. Cou	unty of Deatl	h	
		Stella Maris				If Under 1	OWSC	on If Under:	04 Hm Ta	Data of Bio		altim		· E
Funeral Director		5. Social Security Number 214–22–8106	6. Sex 7. 1 X M 2 □ F	Age (In yrs. Ia: 7 9	Yrs.		Days	Hours	Min.	B. Date of Bir (Month, Da Dente	, Year) 20, 192	27 Mar	npiace (State o untry) ryland	r r-oreign
and www.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	y Limits
Marylan a-f show ified at	ţ	Maryland Balti	more		I	undall	K						1 □Yes	2 ∑ No
with the a or 28 be not	Director	10e. Street and Number 7440 Manchester	Road			10f. Zip C		222			10g. Citizen	of What Co	untry?	
death v ms 23a	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	. 13.	Was Decede			igin? (Speci	ify Yes or No		Race - Ame		
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ρ	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force ed 1 X Yes 2 If Yes, Give Year or Date] No		1 □ Yes 2	_	Specify:		ican, etc.)		Black, White e <i>cify:</i> Wh	ite	
72 hou 'natura dical E	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupat	ion ring mos	st of working	,	16b. Kind o	of Business/	Industry	
within ene. than "	duc	Elementary/Secondary (0-12) 12 years	College (1-4	or 5+)		Fighte					Baltir	nore C	ity	
e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, I	_ast)				1		,		, Maiden Sur			
ould b I Ments narked	70	George Sroka	- /T D/-P		405 14-11-	8 44 /				osynsk		04-4- 3	Zin Codo)	
nd 2 sh lith and 27 is m		19a. Informant's Name/Relationsh Eleanor Sroka	ıp (<i>Type. Print)</i> W i	fe		•					er, City or To L, Mary		21222	
es 1 ar of Hea of Hea ritem		20a. Method of Disposition		20b. Pla		sition (Name			July	te	<u> </u>	on - City or	Town, State	
. Page tment tant: It jury o		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (S _i	necify)	Bay		Cremato			2007				ity, MI).
permit. Pages 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene "Important: If flem 27 is marked other than "natural any injury or other traumatic event, the Medical Expone."		21. Signature of Funeral Service I	.icensee) . Conne	lly	Cc	nneil 10 So	Address Fu ller	of Facilit nera s Po	I Home	e Of I	Oundall Oundall	c, P.A c, MD.	21222	
200		23a. Part1. Enter the disease or shock, or heart failure. List			Do not ent	er the mode	of dying						Approximat Interval Bet Onset and I	ween
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death))INSTI		cana	ev							
Examiner -				as a conseque	ence or):									
Pu to	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or	as a conseque	ence of):									
sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a conseque	ence of):									
# % # I	cal		d											- <u></u>
leath certificat attending phy	/Med	IF FEMALE:	23c. If yes, outco	me of pregnan	nev									
The law requires that the death certificative law requires that the death certificative has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐Live birt	n 2 □ Fetal of t at time of dea	déath 3[⊒Ectopic pre ⊒ Other <i>(spe</i>					230	Date of del Month		Year
that the de the by the a		9 ☐ Unknown Part II. Other significant condition	1		ting in the u	nderlying ca	use giver	n in Part I	l.	23e. Did	tobacco use	contribute to	the cause of c	leath?
quires t	ed by									10	Yes 2□N	lo 3□Pr	robably 45	Onknown
has been sige 2 should	Completed									24a. Was			utopsy findings completion of c	
	a)	25. Was case referred to medical						26. Place	e of Death	1□ Yes (Check only	2 No	1 🗆 Yes	2□ No	
hysicia his cer I direct	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 □ E	R/Outpatier		Other	4 □ Nu				Other (Spe	city) WOSP	ICE
ing ing	44.1	27. Manner of Death Natural 5 ☐ Pending		njury Day Year)	28b. Time o Injury	f 28	c. Injury Work?	at ? es 2□		3d. Describe	how injury o	ccurred		
Attencr death	Certification	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	injury - At hon	ne, farm, sti			e3 Z 🗆		Bf. Location	(Street and N wn, State)	lumber or Ri	ural Route Nun	nber,
ital or irs afte ral Dir	Cert	La v		, etc." (Specify)						_				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical		g Physician: To the be aminer: On the basi and manne	s of examinati										S)
To th within To th comp	Me	29b. Signature and title of certifier				29c.	License	number	721			igned (Mont	th, Day, Year)	
1)		30. Name and address of person	who completed cause	of death (Item :	23a) (Type,	Print)	/	1)	1 (
10		DR TARIQ	MAHMOOD	2300	Dul	aney	Vall	241	RQ T	(WO A II	UM, 7	ud Z	1093	
Sta Registr		31. Date filed (Month, Day, Year) JUL 9 3 200	MAN MOCO	istrar's Signati	No.	e '								
		JUL 0 0 200												

	1	For State Registrar	State of Ma	arylan			nt of H te of L		nd Me		giene Reg. No.	0		0130
	Ę.	1. Decedent's Name (First, Middle, Last)					_	1	2. Date of Dea	ith		· · · · · ·	3. Time of Dea
Physiciar /Medica		RUTH STINK	HCOMP	5						Month	Day	20	ear	2:45
Examine		4a. Fecility Name (If not institution, give	street and number)			4b. City	Town, or	Location of	Death		4c.	County of	Death	
	9	JUNERSITY of MORNE	AUX MESIC	ALC	SINTER	(BAL	TIMO				N	A	
Funeral		5. Social Security Number 6. Se	x 7. Age]M 2⊠F		last birthdey)	If Unda Months	or 1 Year Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day 04-18-	Year)	9	Birthpl Coun	lace (State or Fo
Director		217-24-4303	J.W. 261	80	Yrs.					04-18-	-192	7		MD
*	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10	0d. Inside City Li
i e i	0	MD Anne Art	ınde1	Mil	lersvi	110								1 Yes 2 8
28a-	် မ	10e. Street and Number	inder	****	TCLSVI		ip Code			1	10a. Citi	zen of Wh	at Coun	itry?
Department of results and whentar hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examinational Landled at any injury or other treumatic event, the Madical Examinational Director TO Re Commissed by Eurores Director	5	8343 Sycamore Rd.					211	08				.S.A.		,
or iteme 23a or 28a-fe ingermust te natified Funeral Director	e a	11. Marital Status	12. Was Decedent 8	Ever in U.	S. 13.	Was Dec			in? (Spec	fy Yes or No- ican, etc.)		14. Race -	Americ	
a la	2	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 🖺 N	lo	†				Puerto R	ican, etc.)			White,	
A A	2	3 Ø Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ∐ Yes	2X No	Specify:				Specify:	wn	ite
incal incar	Completed	15. Decedent's Edu (Specify only highest grad	ication		16a. Dece	dent's Us	ual Occupa	ation	of working		16b. Ki	nd of Busi	ness/Inc	dustry
u a	<u>a</u> .	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT	use retired	furing most)	or working	,				
E # 8	5	12			Home	make	r					omest		
d oth	e a	17. Father's Name (First, Middle, Last)								First, Middle,				
umatic ever	0	Henry H. Brown								aret A.				
		19a. Informant's Name/Relationship (T)								Route Number	-			Code)
m 27 her t	1115	Mrs. Betty Krieger	/ daught					Rd:		ersvill				2
or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. P	lace of Dispo emetery, crea	natory or	ame of other plac	9)	Da	te	20c. Lo	cation - Ci	ty or To	wn, State
lury (1 \$\times Burial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) \frac{Specify}{2} \subseteq Glen Haven Mem. Park 07-02-2007 Glen Burnie,													
mport any in		21. Signature of Funeral Service Licens								gleton				
25 4 a	4	1/1/11/1		3145						Glen Bu		e, MD	210	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lin	the death	n. Do not ent	er the mo	de of dyin	g, such as c	ardiac or	respiratory arr	rest,			Approximate Interval Betweek Onset and Deat
sician		Immediate Cause (Final disease or condition	. BRAIN	To	mor.									18 days
edical miner		resulting in death)	Due to (or as a	a consequ	uence of):									- 0
		Sequentially list conditions,	b. Due to (se as a		Caracter office									18 day
sit o		Sequentially list conditions, if any loading to him so attactions. Enter Underlying Cause (Disease or injury	Cabicoloridas	s-suckrespc)s	adrice ory									
hysicien and the burial-transit	Yall	that initiated events resulting in death) Last	c. Due to (or as a	a consequ	uence of):								_	
the buria			-	,										
physicie s the bur	5		d											
attending p	/ Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						1	23d. Date of	of deline	
d by the attending etached for use a	200	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗍 Fetal	death 3[Ectopic Other (s	pregnancy				1	Month		Day Year
ed by the detached	38	1 Yes 2 No 9 Unknown	9□ Unknown		Juli 3 2	1011101	,poc.,y/							
		Part II. Other significant conditions co	ntributing to death bu	ut not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	se contrib	ute to th	e cause of death
d be d	3									1 🗆 Y	es 2[□No 3	☐ Prob	ably 4, aunkr
page 2 should	5						_			24a. Was a	20	24h Wa	re autor	psy findings avai
page 2	<u>.</u>	, , , , , , , , , , , , , , , , , , ,							_	autops	SV	Dric	or to cor	npletion of cause
certificate rector, pag		25 Man ages referred to medical									med? 2 No	10	Yes	2 HNO
	0	25. Was case referred to medical examiner?	Hospital:				Othe).r.		Check only or		_	_	
ral di	2 Individual 2 Ind									()				
After		1 SNatural 5 ☐ Pending	(Month, Day	Year)	Injury	м		(? Yes 2 ∐ N		d. Doddilbo iii	OW III JUI	y occurred		
Director: in by the	20	3 ☐ Suicide 6 ☐ Could not be	28e Place of Init	irv - At ho	me farm str					ocation /S	treet an	d Number	or Bura	I Boute Number
Director: In by the	27. Manner of Death C Natural 5 Pending 2 Accident Injury 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe ho									Or Fibra	r rioute ivaniber,			
To the Funeral Directompletely filled in by											er as st	ated.		
the P	one) and manner stated.													
To the Funeral completely filled	2	29b. Signature and little of certifier					c. License			2	29d. Dat	e signed (Month, l	Day, Year)
7		1/1/	MY			\	1551	5			Ju~	10,2	. 2	500
		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type,	Print)						1		
	1	MANUS CHESISS 20	J. GREST	18 3		TIM	ORE	3 AM	JG16	10				
State Registrar		31. Date filed (Month, Day, Year)	32. Angistra	ır's Signa			-							

DHMH 17 Rev 1/2001

ORIGINAL

07-04884 Edward K. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Lawara IX. Omiti		- For State	Ce		ate of Death	and mone	a. 117910	Reg. I	No. 20	7 7133
Physiciar	1/	1. Decedent's Name (First, Middle,Last)						ate of Death		3. Time of Death
Medical Examin		EDWARD K. SMITH					Ju	ne 27, 200)7	0733 hrs
(4a. Facility Name (if not institution, give stre Good Samaritan Hospital	eet and number)		4b. City, Too	vn, or Location of	Death		4c. County of E	Jeath
Europol	4	5. Social Security Number 6. Sex	7. Age (In yrs.	last hirth			24Hrs. 8. I	Date of Birth(N/A MM/DD/YYYY) 9	9. Birthplace (State or
Funeral Director		218-76-4380 1XXM		39	Yrs. Months	Days Hours	Min.	SEPT 25	F	oreign MARYLAND
any.	+	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town	or Location					10d. Inside City Limits
nd thow t		MARYLAND N/A			BA.	LTIMORE				1 X Yes 2 No
farylar	Director	10e. Street and Number			10f. Zip C			10g.	Citizen of What	Country?
Sa or Sa or		1360 STONEWOOD RI)			239			U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12 1 X Never Married 2 Married	Was Decedent Ever in U Armed Forces? Yes 2 X No	J.S.	13. Was Decedent If Yes, specify	of Hispanic Origii Cuban, M exican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - A White, e	American Indian, Black, etc.
after all', o	by F	3 Widowed 4 Divorced of Year I	es, Give Year			X No specify:			Specify: E	
hours		15. Decedent's Education (Specify only hi			Decedent's Usual Or during most of working			ione 16	6b. Kind of Busin	ness/Industry
36 iin 72 han "	E E	Elementary/Secondary (0-12) GED	College (1-4 or 5+)		FACTORY I	MORKER			FOOD SE	ERVICES
MD 21215-0036 d.z. should be filed within 7 th and Mental Hygiene n. 27 is marked other than aumatic event, the Medica aumatic event, the Medica	Completed	17. Father's Name (First, Middle, Last)			TACTORI		Name (Firs	t, Middle, Mai	den Surname)	-1(12020
215 be file trail H. ked o	Be	ROBERT JONES				BE	TTY L	SMITH		
21 nould and Men is mail	의	19a. Informant's Name/Relationship (Type,	Print)		o. Mailing Address					
MC nd 2 sl atth ar m 27 m 27 auma	ļ	Betty L. Smith/Moth			909 Goodno of Disposition (Name		Apt H	., Balt	timore,	Md., 21206
Ore, es la of He If ite		1 X Burial 2 Cremation 3 F	Removal from State	cremate	ory or other place)					
altimore, mit. Pages I a partment of He portant: If ite	Ų	4 Donation 5 Other Specify: 21. Signature o negal/Service Do	MI	ZIC	ON CEMETE	RY ddress of Facility	07-06	-07 1	LANSDOWN	NE, MARYLAND
		The The	peleve		WILLIAM 11206 W	C BROWN NORTH AV	ENUE			HOME P.A.
Physician /Medical		23a. Part Letter the disease, or complicat failure. List only one cause on each li		h, Do no	ot enter the mode of	dying, such as ca	rdiac or resp	oiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
xaminer	-		ocaine intoxica to (or as a consequence					•		Death
ì		Sequentially list conditions, b	10 (01 as a somequence	,-						
	<u>[ĕ</u>	if any, leading to immediate Due	to (or as a consequence							
. 8.	Examiner	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence	of):						
and	副	d								
760, ficate be executed physician and the burial - transit	Medical	X UNPENDED A	#236,PII,27,28a	a−f,	perME,g869,	7/6 <u>/</u> 07 TI				
3760, ificate bo		23b. Was decedent pregnant in the	3c. If yes, outcome of pre Live birth	gnancy 2	Fetal death	3 Ectopic	pregnancy		23d. Date of de Month	elivery Day Year
b.O. Box 687 that the death certific red by the attending detached for use as the detached for use as the detached for use as the second respective to the second respectiv	Physician/	past 12 months?	Pregnant at time of o							
Bo le deat the at	ş	1 Yes 2 No 9 Unknown						On Did total		ute to the cause of death?
that the order of detach	by P		ntributing to death but not	resulting	g in the underlying o	ause given in Par	π1.			Probably 4 V Unknown
Records, F The law requires cate has been sign	ed led	<u>Complications of 1</u>	iver cirrnosis				#	24a. Was an	1 24b. We	ere autopsy findings available
Orc law re has be 2 sho	Completed		· · · · · · · · · · · · · · · · · · ·					autopsy perform	ed? de	or to completion of cause of ath?
Rec The lifcate	틼							1 ✓ Yes 2	No 1	Yes 2 No
ital ician: s certi	8	25. Was case referred to medical examiner?	ital: 1 Inpatient 2	FR/O		Other:	Nursing Ho		esidence 6	Other:
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury			Sc. Injury at Work			w injury occurred	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ra after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	힐	1 Natural 5 Pending	(Month, Day, Year) FND 6/27/2007	7 unk		1 Yes 2 X	No ur	ık		
ivisior or Attend after death Director:	틸	2 Accident Investigation 3 Suicide 6 X Could not be	28e. Place of Injury - At			office building, etc	c. 28f.			or Rural Route Number, City
Div Hospital of 24 hours at Funeral D	팅	4 Homicide determined	(Specify) sidewa	alk			KD.	Baltim	ore, MD	en Blvd. & Kilmore
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a	Medical Certification:	one) 2 Medical Examiner:On	To the best of my knowle the basis of examination	dge, dea	ath occurred at the t nvestigation, in my	ime, date and place opinion, death occ	ce, and due curred at the	to the cause(time, date an	s) and manner a id place, and due	es stated. e to the cause(s)
To To	ĕ	29b. Signature and title of certifier	d manner stated.			License number				(Month, Day, Year)
		ano I				O.C.M.E.			June 28, 200	07
	1	30. Name and address of person who com								
ϕ			Medical Examiner		Penn Street, Ba	altimore, MD	21201			
Sta Registi	ite rar	31. Date filed (Month Dato Yes) 2007	32 Aegistrar's Signa	in the	Spark					

		1 - For State Registrar		of Ma	arylan		artmen rtificat					g. No.	107	21334
Physici	an	Decedent's Name (First, Middle	e, Last)								Date of Deat Month	Day	Year	3. Time of Death
/Media		Henry E. Smi									June	26,	2007	03:57 A M
Examir	ner	4a. Facility Name (If not institution	_				4b. City,		Location of	of Death			nty of Death	
		Greater Baltin 5. Social Security Number	ore Medic	-		er last birthday)	If Under		SON If Under	24 Hrs	8. Date of Birth	E	Baltin	
Funeral Director		214-38-1753 Usual Residence of Decedent	1⊠M 2□F	/. Ag	64	Yrs.	Months	Days	Hours	Min.	Month, Day, July 29	Year) 1942	2 N	nplace <i>(State or Foreign</i> untry) Maryland
portition of the proof of the control of the control of the many of the control o		10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Mary H	to	Maryland B	altimore			т	owson						İ	1 ☐ Yes 2X No
r 28a	Directo	10e. Street and Number	.arcimore		1		10f. Zip			-	10	og. Citizen o	of What Cou	untry?
h with	O E	8 Chote Ct., U	nit B					2	1204			Ţ	J. S.	Α.
deat	Funerai	11. Marital Status	12. Was Dec	cedent	Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)			ncan Indian,
or Its		1 ☐ Never Married 2 💢 Mar					1 ☐ Yes		Specify:		nican, etc.)		lack, White	
Dours Jrail,	d by	3 Widowed 4 Divorced	Year or	Dates:					Opcony.			Spec	Wh	ite
72 t	Completed	15. Deceder (Specify only highe	it's Education st grade completed)		16a. Deced	kind of wo	rk done o	turina mos	t of worki	ing	16b. Kind of	Business/l	ndustry
Marthin Marthin	m du	Elementary/Secondary (0-12)	College	(1-4or 5	5+)		DO NOT us					۸ م	1** 0 ** + +	icina
lied y		17 Father's Name (First Middle	(4 () () () ()			A	avert	1sin					lverti	ISING
ad o	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										ame,		
d Me d Me mark	2	19a. Informant's Name/Relations	thin (Type Print)			10b Mailir	a Addrocc	/Street			I Route Number,		m Stata 7	in Code)
d2s d2s than trau		Jane M. Smith					-				Towson,			
Heal Heal Sther		20a. Method of Disposition	(WIIE)		20b. P	Place of Dispo	sition (Nan	ne of		-		20c. Location		
ages nt of t: # 15		1 Burial 2 Cremation		State	1	emetery, crer	•			7/02				
mit. Pages partment of portant: If it y injury or e		4 □Donation 5 □ Other (S 21. Signature of Euperal Service			Ба	yview					/200/ E			Maryland
Dermi Deput Importante				•							limunek . Baltimor			
111111111111111111111111111111111111111		23a. Part1. Enter the disease, or	complications that	caused	the deat	-								Approximate Interval Between
Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aDue to	each la	ne. Ma a conseq	relieu uence of):	lm	ifa	ncj	40	n			Interval Between Onset and Death
be executed icien and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G		a consequence		æer							, yrs
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phys completely filled in by the tuneral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth mant at	of pregna 2 Feta t time of d	Ideath 3□	Ectopic pro Other (sp			Vi.			Date of delivery of the contract of the contra	very Day Year
equires that en signed to outd be det	ξ	Part II. Other significant condition	ons contributing to	death b	ut not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did tob			the cause of death?
vital nector, page 2 shirector, page 2 sh	Comple	autopsy prior performed? death									o. Were aut prior to c death? 1 🗆 Yes	topsy findings available completion of cause of		
cian	Be	25. Was case referred to medica examiner?						Ī ou		of Death	Check only one)		
Physic this c	ို	1 Yes 2 No		Inpatie	$-\sim$	ER/Outpatien			4 🗆 Nu		me 5 ☐ Reside			cify)
ding Phys	on	27. Manner of Death 1 Natural 5 ☐ Pendir	19	of Inju	y Year)	28b. Time of Injury		8c. Injury Work			28d. Describe ho	w injury occ	urred	
To the Hospital or Attending Physician: The within 24 hours alter death. To the Funeral Director: Atter this certiticate his completely filled in by the tuneral director, page	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 4 Month, Day Year) 28b. Time of Injury 4 Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										ral Route Number,			
To the Hospital or Attent within 24 hours atter death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical one)	ng Physician: To the Examiner: On the	basis of	f examina	wledge, death tion and/or inv	estigation,	in my op	oinion, dea	d place, a th occurre	and due to the ca ed at the time, da	use(s) and i	manner as e, and due	stated. to the cause(s)
To	Σ	29b. Signature and the of certifie	111111.		, ,,		290	License	number	20	29	d. Date/sign	ned (Month	, Day, Year)
- 4		· Ulyuna	uuu	w	M	7	1	13	707	17		0/20	110	/
25 Y		Rodney VI	who completed cau	5	MD	67	Print)	J.C	ha	rle	sSt. 7	22410	n, M	Dalaot
Sta Registr		31. Ďate filed (Month, Day, Year)	2007	Registr	ar's Signa	iture	. P				•			

		For Amend #6.per	ase Type or State FH,G869, 7/1	of Marvla	nd / Dep		Health a	and Mental I	Hygiei	ne	9,	
Physici /Medic	ai	1. Decedent's Name (First, Mid Sammie E1 4a. Facility Name (If not instituti	izabeth S	Smith		4b. City, Town,		2. Date or Month July	2,	Day Ye 2007 4c. County of D		3. Time of Death 12:00 P M
Funeral Director	ier	Gilchrist Hos 5. Social Security Number 234-34-0426		er	s. last birthday) Yrs.	Tows	on If Under		Righ	I	Balt	imore ace (State or Foreign y)
D D	tor	Usual Residence of Decedent 10a. State 10b. Coun	timore		City, Town or Lo			11149 /	, 17			d. Inside City Limits
perfull Designation of the Maryland ALL 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10e. Street and Number 112 Longda. 11. Marital Status	Le Road 12. Was De Armed I			10f. Zip Code	21093 Hispanic Ori] igin? (Specify Yes o n, Puerto Rican, etc.		Citizen of What USA 14. Race - A Black, V	America	n Indian,
in 72 hours aft in "natural", or Medical Exami	Completed by F	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce 15. Decede (Specify only high Elementary/Secondary (0-12)	ed If Yes, C Year or ent's Education eest grade completed	Dates:	16a. Dece	1 Yes 2 No dent's Usual Occu kind of work done DO NOT use retire	pation	et of working	16b	Specify:		
ridillo 6 16 Juld be filed with Aental Hygiene rked other tha tic event, the I	To Be Com	9 17. Father's Name (First, Middle Samuel James (e, Last)	. '	Switc	hboard O	18. Mothe	or ers Name <i>(First, Mic</i> anie Davis	ddle, Maio	,	nic	ations
ite, Iviary s 1 and 2 shou f Health and N item 27 Is ma other trauma		19a. Informant's Name/Relation Beverly Juani 20a. Method of Disposition	ta Crook/I	20b.	210	ng Address (Stree 09 Keeney osition (Name of matory or other pla	y Mill	Date	eela	nd, MD Location - City	210	53
Dallillor permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 M Cremation 4 ☐ Donation 5 ☐ Other 21. Signature of Larera Service		M€	tro Cr	ematory 2. Name and Addr emmon Fur	ess of Facilit	Home of D	ualn		ey,	
Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complications that st only one cause on		ath. Do not en	ter the mode of dy	ing, such as		ry arrest,	MD 2109		Approximate Interval Between Onset and Death
e be executed sician and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		equence d):	Alte	Ny (disens	2		1 4	years)
the death certificate y the attending phy ched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome pf preg e birth 2 □ Fe gnant at time of rnown	etal death 3	□Ectopic pregnand □ Other (specify) _	су			23d. Date of Month		y Day Year
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Pr	Part II. Other significant cond	tions contributing to	death but not re	200	inderlying cause gi	iven in Part I	24a. \	Did tobaco	2 No 3	Proba	e cause of death? bly 4 Unknown sy findings available upletion of cause of
vitali ician: Th certificate ector, pag	Be Co	25. Was case referred to medic examiner?	cal				26. Place	1	es 2	No 1 🗆		2□No
Attending Physic ar death. rector: After this ce by the funeral dire.	Certification: To E	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident inves	28a. Dat (Mo stigation d not be 28e. Pla	e of Injury onth, Day Year)	home, farm, st	of 28c. Inju	ury at ork? ⊒Yes 2 □	No 28f. Locati	ribe how i	njury occurred		Route Number,
e Hospital on 24 hours after Funeral Directly filled in	edical Cer	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic	ring Physician; To t al Examiner: On the and ma	he best of my ke basis of exami anner stated.	nowledge, dea nation and/or i	th occurred at the	time, date ar	nd place, and due to	the caus	e(s) and manne	er as sta due to	ated. the cause(s)
To th within To th compl	Me	29b. Signature and title of conti	Show	, Nie	y . u		nse number	es St. 0		Date signed (A		
Sta		30. Name and address of personal street of personal street of the street	7 GB	Registrar's Sig	6701	M. C	harl	es St. a	Ba	lto. N	11	20208
Registi DHMH 17 Rev 1/2		JUL 0	3 2007	33440	JS: A	RIGINAL						

		-	For Amend It	Type or Print AMEND TIFM#1 State of Man em 23a,26 I	in Black II 5.17,18.20 Vland / Der Verb	ndelible a-c 22 1 a-timest artificate	Ink. Ensure A erfH 5869,7/2/ 9,09703,709 of Death	II Copie Mental H	ygiene	gible.	9 1 3 8 5
			Registrar 1. Decedent's Name (First, Middle, Last)	0.0	Filmoale	OI Death	2. Date of [Reg. No.	001	3. Time of Death
	ysici: Medic		Kevin Alvin	Smith				June		2007	346 am
	kamin	CI.	4a. Facility Name (If not institution, give May Jand Green 5. Social Security Number 6. Se	neral Ho	Sprtal	Bal		+ +4		unty of Death	place (State or Foreign
	neral ector			Д М 2□F	56 Yrs.	Months	Days Hours Min.	8. Date of E (Month, I May 2	7, Year) 7, 1951	- Cou	ntry) unk
and		-	Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or	Location					10d. Inside City Limits
Maryl	fied a	to	MD		Ва	altimor	e				1 ▼Yes 2□No
ith the	e noti	Director	10e. Street and Number			10f. Zip 0		-	10g. Citizen	of What Cou	ntry?
ath w	nust k		505 Dolphin Stree		win II C 4	2 Was Dands	21217	Pagifu Van ar I	US 10	SA Race - Ameri	can Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperfurment of Feath and Mertal Hi glene. Innordant: If them 57 is marked other than "natural" or thems 23a or 28a-f show	xaminer n	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	erin U.S.	If Yes, speci	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer D No Specify:	to Rican, etc.)		Black, White, ecity: bla	etc.
72 hou	ical	ted	15. Decedent's Edi	ucation de completed)	ı (Gi	cedent's Usual	done during most of wa	rking	16b. Kind	of Business/Ir	ndustry
d within 72 hours af giene.	the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life	. DO NOT use	eretired) nitorial		ho	spital	.s
al H'g	vent,	BeC	17. Father's Name (First, Middle, Last)			-	18. Mother's Na	me (First, Midd		rname)	-unl
id 2 should be file the and Mental High and Mental High syrism arked other than the control of t	natic e	ြို	James Smith	Fine Drink)	10h Ma	ilina Addrona	Street and Number or R			wen Stata Zi	n Code)
Mangarian of the property of t	traun		19a. Informant's Name/Relationship (7) Annette Lee/niece	уре. Рппі)			nin Street 1		-		p code _/
is tar	offher		20a. Method of Disposition		20b. Place of Dis		e of	Date	7	ion - City or T	own, State
Pages ment of	ury or	1	1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ∭ Other (Specify		Garrison 1			-2007	Balto.		Count as D-t-
partitioner, permit. Pages 1 ar Department of Her	any inj		21. Signatus Funeral Service Licent Ronald S.	Wide Direc	tor 4		Address of Faculty Cal	# 655 W	Balt	imore '	trut
executed	dical niner	Il Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to prias a c	consequence of):	Termina	d Aspiratio	on			Poset and Death Immediate hours
The law requires that the death certificate be	detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death ne of death	3□Ectopic pre 5□Other <i>(spe</i>	ecity)		-	. Date of deliv	Day Year
OS, 1 lires th	should be det	l by	Part II. Other significant conditions of Diabetes melli	•	not resulting in the	e underlying ca	use given in Part I.		u tobacco use ⊒Yes 2 😭	,	the cause of death? bably 4 Unknown
LIVISION OF VITAL RECORDS, If or Attending Physician: The law requires t aller death of the this confined has been since	9	Completed by	Hypertension					pe	rformed	prior to c death?	topsy findings available ompletion of cause of
VICAL P ilcian: Th	tor, pa	Be	25. Was case referred to medical	lconol ac	iuse in	past	26. Place of De	1 Ye: eath (Check onl		1 ☐ Yes	2 □ No
Or VILA Physician:	2 등	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 DER/Outpat		Home 5 5 h	esidence 6	Other (Spec	eify)	
ing P.	unera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Bc. Injury at Work?	Injury at Work? 28d. Describe how injury occurred 1 □ Yes 2 □ No					
To the Hospital or Attending Ph within 24 hours after death.	i by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Í	- At home, farm, (Specify)	street, factory			n (Street and Number or Rural Route Number, Town, State)		
To the Hospital or within 24 hours are	e runera	Medical Co	29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of e and manner state	xamination and/o	eath occurred a r investigation,	at the time, date and plac in my opinion, death occ	ce, and due to t	he cause(s) ar ne, date and pl	nd manner as ace, and due	stated. to the cause(s)
To th within	comp	Me	29b. Signature and title of certifier	1			License number			signed (Month	-
E.			> Svargled	ho			D0035363		6	119/0	7
	4	() i	30. Name and address of person who	hallmo i	BVAMC	io N.	D0035363 Greene St	rest E	Saltin	we,	UD 21201
R	Sta legist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature						

07-05041

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kon	iaid Smith		State of M I-For State Registrar	laryland / Departmen <i>Certificate</i>	t of Health and Mental of Death	• •	. No. 200	7 2138
Me	Physicia dical Exami	ın/	Decedent's Name (First, Middle,Last)	5,	so: Ha	Date of Death Month	Dav Year	3. Time of Death 0300 hrs
	aroar Exami		4a. Facility Name (if not institution, give stree	t and number)	4b. City, Town, or Location of De	July 2, 2007	4c. County of Death	
	1		Maryland General Hospital		Baltimore City	**		
	Funeral Director		5. Social Security Number 6. Sex 220-64-7222 1XM	7. Age (In yrs. last birthda		Hrs. 8. Date of Birth Min. 03 2.7	/ Foreign	thplace (State or gn ountry)
	any.	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	and F show	ь	MD	Ba	Himore			1 Yes 2 No
	Maryl	Director	10e. Street and Number	0	10f. Zip Code	100	g. Citizen of What Cou	ntry?
ن	nth the s 23a o	교	766 Cumming 11. Marital Status 12.	S LOUT + Vas Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14 Race - Amer	ican Indian, Black,
	Jeath w	Funeral	1 Never Married 2 Married	vmed Forces?	If Yes, specify Cuban, Mexican, Pu		White, etc.	roam maiam, black,
	after o	by F	3 Widowed 4 Divorced If Yes, or Dat	Give Year es:	Yes 2 X No specify:		Specify: B	ack
	2 hours "natu	ted	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	nest grade completed) 16a. Dec duri	edent's Usual Occupation (Give kind ng most of working life. DO NOT use		16b. Kind of Business/	Industry
	036 ithin 7 ne. r than	Completed	12	En	vironmental Se	ruices	-lohns l	tooking
	Hygie d other	e Co	17. Father's Name (First, Middle, Last)	6 111		ame (First, Middle, Ma	aiden Surname)	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than	믱	19a. Informant's Name/Relationship (Type, P	20 17 19b. M	ailing Address (Street and Number	or Rural Route Numb	er, City or Town, State	Zip Code)
			Sandy M. Smith	1:1.0	06 Cummings	s Court 7	Baltimore.	MD 21201
	s I and I Heal		20a. Method of Disposition 1		sposition (Name of cemetery, or other large)	Date	20c. Location - City or	Town, State
	Baltimore, MD permit Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify:	- Hallin	nore National	7 10 2007	Baltim	ore, MD
)	Balti permit Departm Importa injury o		21. Signature of Funeral Service Licensee	-	22. Name and Address of Facility P	CI. T	eatherford Bull	UN 71712
	Physician	1	23a. Part I. Enter the disease, or complication failure. List only one cause on each line			ac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
	/Medical Examiner		Immediate Cause (Final disease a. Me		n complicated by here	titis		Death
		-a	Sequentially list conditions, if any leading to in recipite Luc to	(or as a consequence of):				
	20.	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):				
	nd ransit	Ä	d.					
	be exec ician a	Medical	X UNPENDED X AME	NDED 20b per ih gs a,27,28a-f, perME,g8	70 8-24-07 vt 369, 7/13/07 TT			
	, P.O. Box 68760, rest that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	n/Me	IF FEMALE: 23c 23b. Was decedent pregnant in the	. If yes, outcome of pregnancy Live birth 2	Fetal death 3 Ectopic pre	egnancy	23d. Date of deliver Month	y Day Year
	ox 68 at the cert at the cert or use a	sicia	past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of death 5	Other (Specify)			
	b. Bc the dea	Physician/	Part II. Other significant conditions contri	Unknown	the underlying cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?
	ires that	ē		batting to godin bat not rooming in	and analonying season growing and	-		bably 4 🗹 Unknown
	rds,	Completed				24a. Was ar autops		utopsy findings available completion of cause of
	Reco	g III				perform	ned? death?	es 2 No
	tal R	BeC	25. Was case referred to medical examiner?		26.Place of Death (Che	eck only one)		
	Physicer this	٩	1 ✓ Yes 2 No	i Inpatient 2 ♥ Ervoutpa	ttient 3 DOA Other ₄ Nu		Residence 6 Other	r:
	on of ending Pl ath. or: After he funeral	Certification:	1 Natural 5 Pending	(Month, Day,Year) 7/2/2007 unk	1 Yes 2 X No		on injury coodinou	
	ViSi or Atte fier de Directo	ifica	Z Accident investigation	8e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (St		ural Route Number, City
	Spital hours a neral	Sel	4 Homicide determined	Specify) found at home		406 Cummi	ngs Ct. Balti	more, MD
	Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On th	e basis of examination and/or inves	occurred at the time, date and place, stigation, in my opinion, death occurr		• •	
_	To COIL	Mec	29b. Signature and title of certifier	nanner stated.	29c. License number		29d. Date signed (Mo	onth, Day, Year)
1			Doma mincenti,	M.D.	O.C.M.E.		July 2, 2007	
	10	.	30. Name and address of person who comple Donna M. Vincenti, MD Assis	stant_Medical Examiner	111 Penn Street, Baltimore	, MD 21201		
		ate	31. Date filed (Month, Day, Year)		onli			
	Regist	ar	JUL 0 3 2007	Bleder At 19				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene perFH, GSO9, //11/0/CTT / Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Vear **Physician** Stanley Paul Zolenas, Sr. 06 30 2007 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air, Maryland
If Under 1 Year | If Under 24 Hrs. | 8. D Upper Chesapeake Medical Center Harford Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1**X** M 2 □ F 90 05/09/1917 Director 215-05-1320 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Upper Falls 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21156 U.S.A. 11000 Raphel Road 21150 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 General Foreman Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Zolenas Tefolia Salchunas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Josephine F. Zolenas P.O. Box 51 Upper Falls, Maryland 21150 21156 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 07/03/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21087 11750 Belair Road - Kingsville, Maryland agga 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumoma disease or condition resulting in death) /Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 3□ DOA 2 ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of ceptified (910, 2111) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Q/IW/II 4A 31. Date filed Month, Day, Year)

3 2007

Upper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b c per fh e869 7-23-07 vt. State of Maryland / Department of Health and Mental Hygiene amend item 20b, c per the 870 8-24-07 vt 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death MonthUNE Daye. **Physician** 2007 1:21P M Charles M. Shadle /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F Maryland 85 219-07-8979 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. 8800 Walther Blvd #1501 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Chemical Corps U.S. Army other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ew Martha G. McCall Charles S. Shadle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hildegarde Shadle (Wife) 8800 Walther Blvd. #1501 Parkville, MD 21234 20b. Red Arep Min of the Green 20a. Method of Disposition Date 20c. Location - City or Town, State Balto. Bel Air 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Bel Air Memorial Gar. 107-02-2007 Bel Air, Maryland 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee pino 0 Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of):
FULMONARY EDEMA Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed ADULT RESPIRATORY DISTRESS SYNDROME attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 | Yes 2 | No 3 | Probably 4 X Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P 5 ☐ Pending investigation within 24 hours after uccommodate to the Funeral Director: After a smaller of the further than the further t 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D46356 une 28,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON. KHOSROW TABASSI 7601 OSLER DRIVE MARYLAND 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

32: Begistrar's Signature

			For State of N	/laryland			nt of H te of L		d Mei	ntal Hy	giene Reg. No	C. U.		1 1	99
			1. Decedent's Name (First, Middle, Last)						2.	Date of De	eath Da	v \	ear/	3. Time of	Death
86.	Physici /Medic		Marietta Maguire Scully		_					June	28		07	9:00	A^{M}
Yes .	Examin		4a. Facility Name (If not institution, give street and numbe 7712 Greentree Road	ir)		4b. City		Location of D		da	4c	. County of Mo		omery	
8 /	Funeral			Age (In yrs. I		If Unde	r 1 Year Days	If Under 24 I	∕lin.	Date of Bi (Month, D	ay, Year))	Coun		
	Director		047-10-4541 1□ M 2⊠F	89	Yrs.				M	ay 15	, 19	18	Com	nectic	ut
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation							1	0d. Inside Cit	y Limits
	Maryl f sho ied a	to	Maryland Montgomery		We	st B	ethes	da						1 ☐ Yes	2 🙀 No
	r 28a	Director	10e. Street and Number			10f. Z	p Code				10g. Ci	tizen of Wh	at Cour	try?	
	th with		7712 Greentree Road				20	817				Unite	d S	tates	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deceder Armed Forces I □ Yes, Give Year or Dates	s? ⊠No		Was Deci If Yes, sp 1 ☐ Yes		spanic Origin' n, Mexican, P Specify:	? (Specifi uerto Rid	y Yes or Nean, etc.)	0-	14. Race Black, Specify:	White,		
Maryland 21215-0036	2 hour atural cal Ex	ed k	15. Decedent's Education		16a. Dece	dent's Us	al Occupa	ation			16b. K	and of Busi	ness/Inc	dustry	
712	hin 72 3. an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	or 5+)	_			luring most of)	working			D 7	77		
2	d with	mo U	4	,	Inv	esto	r					Real		are	
b	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's	•	irst, Middle Cashe		n Surname))		
<u>Ş</u>	ould I Men narke	မှ	John P. Maguire		405 14-77		(0)					T O		0-4-1	
Mai	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print) Roger Scully / Son			-	•	and Numbero ire Wa							
<u>.</u> بۇ	1 and Healt Jem 2		20a. Method of Disposition	20b. P	Place of Dispo				Date			ocation - C			
JO.	ages ent of tt: If It y or o		1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ile Mo	ontgom	ery	_	<i>e)</i> J	uly 20	0.7	Ве	thesd	a, I	aryla;	nd
Baltimore,	mit. Fortan		21. Signature of Funeral Service Licensee		remato:	r Lum 2. Name a	and Address	s of Facility hevy Cl	Robe	rt A.	Pum	phrey	Fur	neral sin Av	Jome/
ŭ	Imp Der		· revel	MO 1	433 B	ethe	sda-c	mevy G Maryla	nd 2	0814	100	/ WIS	COIR	STII AV	situe
8760, 1	Physician /Medical Examiner physician and physician and the prual-transit the primary for the	al Examiner	Sequentially list conditions, if any, leading to in include cause. Enter Underlying Cause (Disease or injury that initiated events	lice as a cons <i>e</i> qu	Small	Cel	1 Lun	g Canc	er					Approximate Interval Bet Onset and E	Peath
P.O. Box 687	eath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	n 2□Feta tattime of d	I death 3]Ectopic] Other (:	oregnancy					23d. Date Mont		•	Yea r
ds, P.	w requires that the de been signed by the should be detached	Completed by Ph	Part II. Other significant conditions contributing to death Hypertension	n but not resu	ulting in the u	nderlying	cause give	en in Part I.						ne cause of do	
Ö	v requ been shoul	lete	Atrial Fibrillation							24a. Wa	s an	24b. W	ere auto	psy findings	available
Re	he lar e has age 2	duic							_	auto per	opsy formed?	pr de	ior to co ath?	mpletion of ca	ause of
ta	an; T tifficat tor, pa		25. Was case referred to medical					26. Place of	Death (0	1□ Yes Check only	2 🔯 N one)	0 11	Yes	2□ No	
<u> </u>	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 🗆 🛭	Oth	er: 4 □ Nursii	ng Home	5⊠ Res	sidence	6 □Other	(Specil	iy)	
Division or Vital Records,	r ding Ph th. r. After th e funeral		27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of I (Month, I	attent 3 DOA 4 Nursing Home					how inju	ury occurre	d				
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	ome, farm, sti	eet, facto	ry, office		28f	Location City or To	(Street a own, Stat	ind Numbei te)	r or Rura	al Route Num	ber,	
	ne Hospital	Medical (29a. Certifier (Check only one) Certifier Check only one Check one Che	s of examina	owledge, deat ation and/or in	h occurre	d at the tir	ne, date and p pinion, death	place, an occurred	d due to the at the time	e cause(e, date ar	s) and man nd place, ar	ner as s nd due t	tated. o the cause(s	s)
	To tl withii To tl	M	29b. Agnature and title of earti lier		29c. License number					29d. Date signed (Month, Day, Year)					
	,						D500	30				6.28	-7	•	
	100		30. Name and address of pers n who completed cause of David Rogers M.D. 5530 V	n 23a) (Type, .sin Av)(Type, Print) n Avenue, Suite 1400, Chevy C				Chase, Maryland 20815						
	Sta Regist		31. Date filed (Month, Day, Year) JUL 0 3 2007	istrar's Signa	ature	arte	F								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8,18 per fh 9869 7-16-07 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:50am June 28, 2007 Man Mohan Sekhri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville ar If Under 24 Hrs. Montgomery Brighton Gardens If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month Dy, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 579-56-0519 84 August 22, 1922 India Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland <u>Kensington</u> Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20895 **United States** 5305 Bangor Drive filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian Indian 1 ☐ Yes 2 X No Specify: Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 World Bank Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H ant; if item 27 is marked ott Puri Hans Jagen Sekhri Vidya 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: if item 27 is
any injury or other trau 388 Beale Street #1810, San Francisco,California94105 Paul Sekhri/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery July Crematorium inc. 2, 2007 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licenses Len 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, any Lacting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed physician and s the burial-trans Hypertension Due to (or as a consequence of): Box 68760 Physician/Medical Atherosclerotic Heart Disease use as t attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death P.0. this certificate has been signed by the all director, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. ☑ No 2∏ No 1□ Yes 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streel and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 C i ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 M dic Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

Registrar

State

30. Name and address of person who

M.D.

Year)

Ajay Reddy,

31. Date filed (Month, Day,

mpleted cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

D53691

6320 Democracy Boulevard, Bethesda, Maryland 20817-1664

June 28, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Mildred Louise Sarsfield РМ 7:19 25 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 🖸 F 88 479-12-7213 **Director** January 10, 1919 Canada Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Show notified at 1 ☐ Yes 2 No Director Maryland| Montgomery Bethesda r 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or the Medical Examiner must be 8607 Irvington Avenue 20817 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural', or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hermann Ludwig Jeanette Morris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Sarsfield/Son 10301 Snowpine Way, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place Montgomery Cremtorium 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) June 28, 2007 Bethesda, Maryland 21. Signature of Funeral Service Licensee _22, Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction 4 Days /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure 5 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Atrial Fibrillation with rapid ventricular response 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown icate has been : , page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Hypotension induced renal failure autopsy perform 1∐ Yes 2 X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 🔯 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 XNatural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director:

ARSFIELD, MILG

within 24 hours after

To the Funeral Dire

completely filled in by 17

hours after

6 Could not be determined

John M. Chandler, M.D.,

03

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

(Check only

29b. Signature and vitle of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 Koertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0043443

8600 Old Georgetown Rd., Bethesda, Maryland 20814

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

25 2007

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death
		1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time it Death
-	Physician /Medical	
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth
		Fayette Health & Rehab Center Baltimore
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Norths Days Hours Min. 1 North Day, Year) 1 North Day, Year) 1 North Days 1 North
	Director	243-66-4741 124 61 June 2, 1945 Usuel Residence of Decedent
	show ed at	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	r 28a-f sho	MD Baltimore ™DY9es 2□No
	ith th	106. Street end Number 107. Zip Code 109. Citizen of Whet Country?
	auth v	1217 W. Fayette Street 21223 USA 11 Marital Status UNK 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
_	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at humpleted by Eumeral Director	11. Marital Status Unk 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Never Married 1. Yes 2. No No No No No No No No
-0050 -0050	urs af	3 Uvidowed 4 Divorced Feer or Dates:
5003	be filed within 72 hou tal Hygiene. It Hygiene. I other than "natura event, the Medical E	15. Decedent's Education 16e. Decedent's Usual Occupation UNK (Specify only highest grade completed) (Give kind of work done during most of working
9 12	vithin	Elementary/Secondary (0-12) College (1-4or 5+)
0 P	e filed value of the tree of the tree tree vent, the contract of the tree tree vent, the contract of the contr	unk unk 17. Father's Name (First, Middle, Lest) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk
(8) and	should be in and Mental I marked of umatic eve	
Maryland	2 should lend Men's marked aumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Š Z	1 end 2 Heelth e am 27 is	Fayette Health & Rehab Center 1217 W. Fayette Street Baltimore, MD 21223
1 / 2007 Baltimore, Mar		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State
/ mi	parmit. Pages Department of F Important: If Its any Injury or of price.	4 □ Donation 5 🖸 Other (Specify) in state
Bal	parmit Depart Mport Iny In	21. Signature of Foneral Service Ricensee Ronald S. Wade Practor State Anatomy Board 655 W. Baltimroe Street
9 "	40200	Baltimore, MD 21201
		23a. Fert1. Enter the disertion, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
	Physician / /Medical	Immediate Ceuse (Final disease or condition resulting in death) a. METASTATIC LARYNGEAL CARCINOMA a. METASTATIC LARYNGEAL CARCINOMA
3	Examiner	disease or condition resulting in death) a. ITC HSTA IC ARYNGERU CHRUNOMA Due to (or es a consequence of):
9		
	ifficata ba axecuted g physician and as the burial-transit	Sequentially list conditions, Due to (or es e consequence of):
J 6	ba ay	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Due to (or as a consequence of):
68760	ficata p phys s the	resulting in death) Last Due to (or as a consequence of):
Box	= 0,0	
	as that tha deeth cerigned by the attandin be datached for use by Physician/N	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
P.O	at tha	FASCEDUALO DATLY DISTAL TALLUSES 12 Yes 2 No 3 Probably 4 Unknown
	requiras that tha deeth cer been signed by the attandir thould be datached for use eted by PhysicianA	ENCEPHALOPATHY, RENAL FAILURE;
PEN CER	v require	CHRONIC OBSTRUCTIVE PULMONARY DISINSE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
Rec 2	e law has t ge 2 s	of death?
S Pen Cerk Vital Records,	Hen: The law requires that the deeth cer antificate has been signed by the attandir ctor, page 2 should be datached for use Be Combleted by PhysicianA	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
	Physician: The law this certificate has trail director, page 2 start of the Compile.	examiner? 1
n of	ng Phyter this neral neral	27. Manner of Death 128. Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Work?
NES vision	Attending r death. actor: After by the fune	2 Accident investigation 3 Suicide 6 Could not be 2 Successful to the suicide of
N S	or Att	3 Suicide 6 Could not be determined 28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
The state of the s	Hospital 24 hours a Funeral I staty filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as steted.
1.4	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completally filled in by the funeral diractor, page 2. Medical Certification: To Be Comp	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the comple	29b. Signaydre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
1		VColunt E. Toly MD. 10-19425 6/28/2007
		30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
	State	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ROBINT E. ROBY M.D 827 LINDIN AVENUE - BALTIMORE MD ZIZOI 31. Date filed (Month, Day, Year) JUL 0 3 2007 32 Registrer's Signature

ysician		Registrar Decedent's Name (First, Middle		ertifica		Journ		2. Date of Month	Death	Day	Year	3. Time of Deat					
Medical		ANNA	SH								JULY	2	2007		3:10 A		
caminer	4a.	. Facility Name (If not institution	-		ımber)				Location of	of Death			4c. County	of Death			
	5.5	JOSEPH RICHIE Social Security Number	HO 6. Se		7 Age (In vn	s. last birthda		BALTII	MORE If Under	24 Hrs.	8. Date of	Birth		9 Rinth	place (State or For		
eral ector	2	220-74-8262		^ M 2 X	67	Yrs.	Months		Hours	Min.	(Month,	Day, Y	1940	Coui	ntry) MD		
event, the Medical Examiner must be notified at Re Completed by Finneral Director	10	a. State 10b. County			10c. 0	City, Town or	Location IMORE								10d. Inside City Lin		
iner must be notified	10	e. Street and Number				DALL		ip Code				100	. Citizen of	What Cou			
e i	5	1313 N. FULTOR	N A	VENITE			101. 2.1		217			100	US		nuy:		
must	3 11	. Marital Status			edent Ever in	US 1	3. Was Dec			igin? (Sne	ecify Yes or	No-	14. Race - American Indian,				
liner I	š ''	. Marital Status 1 ★Never Married 2 Marri	ried	Armed F	orces?	0.0.	3. Was Dec	ecify Cuba	an, Mexicar	n, Puerto	Rican, etc.)	140		Black, White, etc.			
xam by		3 ☐ Widowed 4 ☐ Divorced	- 1	If Yes, G Year or D	2 X No ive Dates:		1 ☐ Yes	2 XNo	Specify:				Specif	Specify: BLACK			
SalE		15. Decedent	t's Edu	ucation		16a. De	cedent's Us	ual Occupa	ation			16	l 6b. Kind of B	b. Kind of Business/Industry			
Medi	-	(Specify only highes Elementary/Secondary (0-12)	st grad	de completed)		(Gi life	ve kind of w DO NOT i	ork done d use retired	during mos 1)	t of worki	ing				-		
it, the Medical Exar		7		College (1-4or 5+)	H	OUSEKI	EEPER					FA	MILY			
event,		. Father's Name (First, Middle,	Last)			-			18. Mothe	er's Name	(First, Mid	dle, Ma	aiden Surnar				
matic event, the Me		AUBRY				ANN	IE G	REEN									
other traumatic		a. Informant's Name/Relations	19b. Ma	iling Addres	s (Street a			mber, (City or Town	, State, Zip	o Code)						
other tra		MAMIE SHAW/SIS	STE	R		13	20 N.	FULT	ON AV	ENUE	, BAL	TO.	, MD 2	21217			
d the	20	a. Method of Disposition				Place of Dis	position (Na	ame of	(ac		Date	20	- City or To	own, State			
٥		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			State		ry, crematory or other place)						20c. Location - City or Town, State 7 RAT.TTMORE - MD				
듣	<u> </u>	- Deliation - Col			I .	MT. Z	1						ALTIMORE, MD				
· a	21	I. Signature of Funeral Service			0	MT. Z		and Addres		-							
any ir	21	Signature of Euneral Service			len	MT. Z	22. Name a		ss of Facilit	y JA	MES A	. M	ORTON	& SO	NS F.H.,		
any injury or other		* James (Licens	WV.	caused the de		22. Name a	LAUR	ss of Facilit	y JA	MES A	. M	ORTON MORE,	& SO	NS F.H., 1217 Approximate		
	23	3a. Part . Enter the disease, or shock, or heart failure. List	Licens	WV.	caused the de	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian	23 Im	* James (Licens	lications that one call se on	roxe	ath. Do not e	22. Name a	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
	23 Im	Ba. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition	Licens	lications that one call se on	caused the de ach line.	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	23 Im di: re	Ba. Part . Enter the disease, or shock, or heart failure. List namediate Cause (Final sease or condition sulting in death)	Comp only o	licatio s that one cal se on a. Due to	Tote (or as a conse	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	23 Im di: re	Ba. Part . Enter the disease, or shock, or heart failure. List namediate Cause (Final sease or condition sulting in death)	Comp only o	licatio s that one cal se on a. Due to	roxe	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	23 Im di: re	Ba. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition	Comp only o	lication is that one can se on the can se on	(or as a conse	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	Im distre	Ba. Part Enter the disease, or shock, or heart failure. List imediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause. Enter Underlying at initiated events	Comp only o	lication is that one can se on the can se on	Tote (or as a conse	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	Im die re	Ba. Part Enter the disease, or shock, or heart failure. List imediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause. Enter Underlying at initiated events	Comp only o	lication is that one can se on the can se on	(or as a conse	ath. Do not e	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO	NS F.H., 1217 Approximate Interval Between		
cian lical iner	Im die re	Ba. Part Enter the disease, or shock, or heart failure. List imediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause. Enter Underlying at initiated events	Componly	lication is that one call se on the	(or as a conse	ath. Do not equence of):	22. Name a 1701 enter the mo	LAUR	ENS S	TREE	MES A	LTI	ORTON MORE,	& SO MD 2	NS F.H., 1217 Approximate Interval Between Onset and Deat		
cian lical iner	Im die re	a. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate tase. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	Componly	lications that one call se on a. Due to b. Due to d. 23c. If yes, ou 10 Live	(or as a conse	ath. Do not endemone of): equence of): equence of): equence of):	22. Name a 1701 enter the mo	LAUR pregnancy	ENS S	TREE	MES A	LTI	ORTON MORE, it,	& SOMD 2	NS F.H., 1217 Approximate Interval Between Onset and Deat		
cian lical iner	Im die re	3a. Part . Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition soulting in death) equentially list conditions, any, leading to immediate cause. (Disease or injury at initiated events sulting in death) Last FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 Yes 2 Woo	Componly	lications that one call se on a. Due to b. Due to d. 23c. If yes, ou 10 Live	(or as a conse	ath. Do not endemone of): equence of): equence of): equence of):	22. Name a 1701 enter the mo	LAUR pregnancy	ENS S	TREE	MES A	LTI	ORTON MORE, it,	& SO MD 2	NS F.H., 1217 Approximate Interval Between Onset and Death		
cian lical iner	Im dia re	Ba. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate tuse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	componly of	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS S	TREE cardiac c	MES A T, BA or respirator	LTI)	ORTON MORE, it,	& SOMD 2.	NS F.H., 1217 Approximate interval Between Onset and Deat		
cian lical iner	Im did re	a. Part . Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	componly of	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS S	TREE cardiac c	MES A T, BA or respirator dent	LTI) y arres	ORTON MORE, it.	& SO MD 2	NS F.H., 1217 Approximate Interval Between Onset and Deat Warf. ery Day Year		
cian lical iner	Im did re	Ba. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate tuse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	componly of	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS S	TREE cardiac c	MES A T, BA or respirator dent	LTI)	23d. Da Me	& SO MD 2	NS F.H., 1217 Approximate Interval Between Onset and Death Www. Properties of the Constitution of the Cons		
cian lical iner	Im did re	a. Part . Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	componly of	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS S	TREE cardiac c	23e. D	y arres	23d. Da	& SOMD 2. Attended to the state of delivionth attribute to to the state of delivionth attribute attribute attri	Approximate Interval Between Onset and Death Warning Tonger of the Cause of death bably 4 Unknopsy findings avail		
cian lical iner	Im did re	a. Part . Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	componly of	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS S	TREE cardiac c	23e. D	y arres	23d. Da Mccco use con 2 14 No	& SO MD 2. Attended to the state of delivionth when the state of delivionth were autoprior to condeath?	Approximate interval Between Onset and Death Warrington of Cause of death bably 4 Unkn		
cian lical iner	Im dispression of the control of the	a. Part . Enter the disease, or shock, or heart failure. List immediate Cause (Final sease or condition saily leading to immediate use. Enter Underlying ause. Closease or injury at initiated events sulting in death) Last FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 Wo 9 Unknown art II. Other significant conditions.	componly c	ications that one call se on a. Due to b. Due to d. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not equence of): equence of): equence of): nancy stal death	22. Name a 1701 enter the mo	LAURi ode of dying as cu	ENS Sig, such as	ty JA	MES A T, BA or respirator den 23e. D 1 24a. W ai	y arres id toba ☐ Yes //as an utopsy //as 2 [i	23d. Da Mucco use con 2 In No	& SO MD 2. ate of delivonth tribute to t 3 Prol Were autt	NS F.H., 1217 Approximate interval Between Onset and Death Death Death Provided The Court of Court		
cian lical iner	Im dia re	a. Part. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate cause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: the Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown art II. Other significant conditions.	componly c	Justice to the call see on a. Due to b. Due to d. Due to	(or as a consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consector of the consec	ath. Do not of equence of): equence of): equence of): nancy stal death death	22. Name a 1701 enter the mo	pregnancy pecify	ENS Sig, such as	STREE cardiac of	23e. D 1 24a. W an physical Check on	id toba	23d. Da Mucco use con 2 In No	& SO MD 2. ate of delivonth tribute to t 3 Prol Were auture prior to condeath? 1 Yes	NS F.H., 1217 Approximate interval Between Onset and Death W 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		
al director, page 2 should be detached for use as the burial-transit a p p p rector, page 2 should be detached for use as the burial-transit To Be Completed by Physician/Medical Examiner	Im dispression of the control of the	Ba. Part I. Enter the disease, or shock, or heart failure. List imediate Cause (Final sease or condition salty, leading to immediate cause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 D No 9 Unknown at II. Other significant conditions.	componly c	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	(or as a consection of the con	ath. Do not expuence of): equence of): equence of): nancy stal death if death esulting in the	22. Name a 1701 enter the mo	pregnancy cause give	ENS S g, such as an in Part I.	ty JA STREE cardiac c	23e. D 24a. W an ph (Check on me 5 B	id toba ☐ Yes //as an utopsy erformers 2 [v] y one)	23d. Da More coo use con 21 No 24b.	& SO MD 2. Attention of the state of delivion on the state of delivion	NS F.H., 1217 Approximate interval Between Onset and Death W 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		
al director, page 2 should be detached for use as the burial-transit a p p p rector, page 2 should be detached for use as the burial-transit To Be Completed by Physician/Medical Examiner	Im dispression of the control of the	Ba. Part I. Enter the disease, or shock, or heart failure. List immediate Cause (Final sease or condition salty) list conditions, any, leading to immediate tase. Enter Underlying use. (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	Componly of the componity of the componi	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	(or as a consection of the con	equence of): equence of): equence of): equence of): equence of): equence of): anancy otal death death death	22. Name a 1701 enter the mo	pregnancy pregna	ENS S g, such as an in Part I.	STREE cardiac of a control of the co	23e. D 24a. W an ph (Check on me 5 B	id toba ☐ Yes //as an utopsy erformers 2 [v] y one)	23d. Da Mcco use con 211 No 24b.	& SO MD 2. Attention of the state of delivion on the state of delivion	NS F.H., 1217 Approximate interval Betweer Onset and Death W 2 V 2 V 2 V 2 V 2 V 2 V 2 V 2 V 2 V 2		
al director, page 2 should be detached for use as the burial-transit a p p p rector, page 2 should be detached for use as the burial-transit To Be Completed by Physician/Medical Examiner	Im dispression of the control of the	a. Part I. Enter the disease, or shock, or heart failure. List immediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions are in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions are in the past 12 months? 1 Yes 2 No 5 S S S 6 Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 1 Natural 5 Pending investig 20 Accident 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 6 Could restrict 3 Suicide 5 S	componly com	Juste to the call see on the c	(or as a consection of pregations) (or as a consection of pregations) (or as a consection of a consection of pregations) (or as a consection of a consection of pregation of p	ath. Do not of equence of): equence of): equence of): nancy etal death if death esulting in the	22. Name a 1701 enter the mo 3 □ Ectopic p 5 □ Other (s) e underlying eight 3 □ D e of	pregnancy cause give	en in Part I.	e of Death	23e. D 24a. W an ph (Check on me 5	y arres id toba Yes variations and the second se	23d. Da Microson 211 No 24b.	ate of delivonth ate of delivonth tribute to t 3 □ Prol Were autoprior to codeath? 1 □ Yes her (Speciarred	NS F.H., 1217 Approximate interval Between Onset and Death W 2 V ery Day Year the cause of death bably 4 Unknown posy findings avail posy findings avail 2 No		
ector, page 2 should be detached for use as the burial-transit and a second be Completed by Physician/Medical Examiner	Im dispression of the control of the	Ba. Part I. Enter the disease, or shock, or heart failure. List immediate Cause (Final sease or condition salty, leading to immediate use. Enter Underlying use. (Disease or injury at initiated events sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 9 Unknown at II. Other significant conditions. Was case referred to medical examiner? 1 Yes 2 No Man r of Death 1 Natural 5 Pending investig 3 Suicide 6 Could resulting should be could restrict the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered by the should be considered b	componly com	Juste to the call see on the c	(or as a consection of the con	ath. Do not of equence of): equence of): equence of): nancy etal death if death esulting in the	22. Name a 1701 enter the mo 3 □ Ectopic p 5 □ Other (s) e underlying eight 3 □ D e of	pregnancy cause give	en in Part I.	e of Death	23e. D 24a. W au 1 Year 24a. W au 1 Year 28d. Descrii	y arres id toba Yes variations and the second se	23d. Da Microson 211 No 24b.	ate of delivonth ate of delivonth tribute to t 3 □ Prol Were autoprior to codeath? 1 □ Yes her (Speciarred	NS F.H., 1217 Approximate Interval Between Onset and Death W 2		

Anna Shaw To the Hospit within 24 hours To the Funers completely fille

310 AM

State Registrar

JUL 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Iso MD Richey Hospice \$38 N. Eutaw St Balfinore MD 21201

31. Date filed (Month, Day, Year)

32. Destructions Signature

D24170

29d. Date signed (Month, Day, Year)

2,2007

			1 - For State Registrar		f Marylan		artmen rtificate			and M	ental Hy	giene Reg. No.		31395
	Physici	an	Decedent's Name (First, Middle The Company of the Company								2. Date of De Month	aath Day	Yeer	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution	ulia Cathe		piegel	4h Cih	Tour	Location o	of Dooth	June	28	2007 inty of Death	
	Examir	er	St. Elizabeth				4b. City,		timor			40. 000	N/A	1
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under a	24 Hrs.	8. Date of Bir	th Your		nplace (State or Foreign
	Director	1	215 50 0544	1 □ M 2 🔀 F	98	Yrs.	Months	Days	Hours	Min.	(Month, Da Mar. 20) Ma	ryland
pug	3		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ncation							10d. Inside City Limits
Manyla	o ho	ŏ	Maryland N/A			altimo								1X Yes 2 No
the	289-	rect	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	untry?
with	38 07	ā	3220 Benson A	Avenue				212	27			_	S.A.	,
5-0036 72 hours after death with the Maryland	E B	Funeral Director	11. Marital Status	12. Was Dece Amed Fo	dent Ever in U	.S. 13.	Was Deced	dent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		Race - Ame	
36 after	o la	y Fu	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, Giv	2 ∑ No e		1 ☐ Yes :		Specify:	, 1 401101	noan, etc.,		Black, White Books White	
)OO	a Ex	d by	3 ☒ Widowed 4 ☐ Divorced	Year or Da	ates:									
1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	"na" n	ojete	15. Deceden (Specify only higher	st grade completed)		(Give	dent's Usua kind of woi DO NOT us	rk done d	uring most	of working	19	16b. Kind 0	f Business/l	ndustry
2121	r than	Completed	Elementary/Secondary (0-12) 12th	College (1	-40r 5+)	Home	emaker						Own Ho	ome
pul ed	vent,	Bec	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	, Maiden Sun		
Val Suld b	and Mental Hyglene. ie marked other than aumatic event, Ina Me	To	Cor	stantine	Sokolis	3			Ca	ther	ine La	skowska	as	
Maryland 21215-0036	Department or results and weeks trygiene. Importent: If termarked other than "natural; or items 23s or 28e-f show may injury or other traumatic event, the Medical Esaction must be rediffed at ance. Once.		19a. Informant's Name/Relations Geraldine Voi									er, City or To		
e, P	regalln tem 27 other tra		20a. Method of Disposition	ineliboscii	20h F	_	rystal				Alr,	Maryla: 20c. Locatio		
altimore,	Depertment of real importent; if item 2 eny injury or other once.		1 🖸 Burial 2 □ Cremation		State	Place of Dispo cometery, crei			1				-	
I fin	orteni orteni injur)	. 9	4 ☐ Donation 5 ☐ Other (S	-	lete	n Have								e, Maryland
B F	e de sa		Preno	Ulda	idge	2 40	01 Ri	tchi	e Hig	hway	ce run :Balt	eraı Se imore,	ervice Marvl	e, P.A. and 21225
Phy	ysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that confusions one cause on each	aused the death									Approximate Interval Between Onset and Death
Exa	dedical aminer	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	C	or as e conseq or as a conseq		how	,						
ecords, P.O. Box 68760, law requires thet the death certificate be executed	ng physicien and as the burial-transit	cai	IF FEMALE:	d.	or as a conseq	uence of):		-						
P.O. Box	ed by the ettending p detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pro						Date of deliment	very Day Year
ords, F	been signed should be det		Part II. Other significant conditions Deminson (ns contributing to de	ath but not res	ulting in the u	nderlying c	ause give	n in Part I.	-	23e. Did t	101.00	•	the cause of death?
oc E	S C/	Completed by	DIMAISE	posher	Dolles	osil	מבומל	OVX	vcul.		24a. Was auto perfo	an 24 psy prmed? 22 No	b. Were autoprior to death?	topsy findings available ompletion of cause of 2 No
Vita	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				7.00		of Death	Check on y	one		
n of	Alter this funeral di	ition: To	1 Yes 2 No 27. Manner of Death 1 Deathral 5 Pendin 2 Accident investig	28a. Date o	npatient 2 of Injury on, Day Year)	28b. Time of Injury		8c. Injury Work	at ?	2		dence 6 0		(ify)
Division of Attendance of Atte	od in by the	27. Manner of Death 1								1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospitel	To the Funeral Directory of the Completely filled in b	edicai	29a. Certifier 1 certifyin (Check only one)	g Physicien: To the Examiner: On the ba and mann	sis of examina	wledge, death tion and/or in	h occurred a vestigation,	at the tim- in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
T of	Tol	Σ	29b. Signature and title of certified	0-	1	1		. License				29d. Date sig	ned (Month	, Day, Year)
•		114	Colmul	f. 1	Laun			D	34	95	/	Alm	28	2007
19	D		30. Name and address of Person	JENO.	up		Frint	inch	Ro	dr.	4100	Com.	Ale 1	2007 D21218
	Sta Registr		31. Date filed (Month, Day, Year)	2007	egistrar's Signa	ture Cou	Well !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Month 29 9:15 A M June Orlando Charles Schiavone 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 20,1920 | Atlas, Stella Maris Nursing Center Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 204 03 2807 86 Penna. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 ☐ Yes 2 ☐ No Maryland Baltimre Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 201 N. Essex Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1X1 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 □ Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schiavone Elizabeth Gidaro Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 230 Commodore Drive Essex Maryland 21221 Michael Schiavone (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 7/2/07 Baltimore County Maryland □Donation 5 □ Other (Specify) ature of Funeral Service I censee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death Enter the disease, or co mplications that caused the de the one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Cause (Final condition death) EUMONIC vee Due to (or as a consequence of) HMYOTYO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autonsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

P.O. Box 68760 Records, or Vital

SCHIAVONE,

attending physician and After t

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

23a

or Items

"natural"

than

other 1

h and Mental h and 2 should be

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

Physician /Medical

Examiner

Director

Funeral

þ

Completed

Be

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

1-2-Natural

2 Accident

4 🗌 Homicide

(Check only one)

29b. Signature and title of ceptifier

3 ☐ Suicide

29a, Certifier

the Maryland

with ō

Maryland 21215-0036

Ø

Hospital or Attending Physician: Division 4 hours after death. Funeral Director: / within 24 hours at To the Funeral D

1041 State

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

FRNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 Could not be determined

32 Registrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TIMONIUM

29d. Date signed (Month, Day, Year)

21093

8. Date of Birth (Month, Day, Year) July 22,1944 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 X No

2. Date of Death

30

Day

2007

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Month

June

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

Black. White, etc. Specify: White

16b. Kind of Business/Industry

14. Race - American Indian,

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12

Burner Steel Mill 18. Mother's Name (First, Middle, Maiden Surname)

William Delmas Simpson 19a. Informant's Name/Relationship (Type. Print)

3 ☐ Widowed 4 ☑ Divorced

17. Father's Name (First, Middle, Last)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Lisa Sherman (Daughter) 20a. Method of Disposition

2220 Turkey Point Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date

Joan Marie Caroff

1XXBurial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Sacred Heart Of Jesus 07/06/2007 Baltimore, Maryland 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A.

21. Signature of Funeral Service Licensee

1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

altimore, Maryland 21215-0036

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

ate has been signed by the atte page 2 should be detached for

certificate has

After

within 24 hours after To the Funeral Dire

filled in by the funeral director,

the Hospital or Attending Physician:

2

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760分

þ

Completed

Be

Examine

Physician/Medical

ģ

Completed

Be

ပ

Certification:

Medical

Due to (or as a consequence of)

Myocardial Infarction

Approximate Interval Between Onset and Death

3. Time of Death

7:18

Birthplace (State or Foreign Country)

 P^{M}

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

2 Fetal death 4☐Pregnant at time of death 9□Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 🏋 Probably 4 ☐ Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

autopsy performed? Yes 2XXNo 1□ Yes

28d. Describe how injury occurred

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 🗓 O 3□ DOA XXER/Outpatient

27. Manner of Death XX Natural 5 □ Pendina investigation 2 ☐ Accident

determined

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? Injury M

1 TYes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Mccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number D-53298

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drew Fuller, M.D.

Johns Hopkins Bayview Medical Center, Baltimore, Maryland

31. Date filed (Month, Day, Year) 2007 0 3

32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Phyllis Mae :100 Sykes 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Kosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/31/1943 Birthplace (State or Foreign Country) West Virginia Social Security Number **Funeral** Days Months Hours 1 □ M XXF 64 Director 216-42-6702 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Farwind Drive, Apt. 1-B 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 滋茂 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 0 1 ☐ Yes 2 2 No Specify: þ White 3 Widowed 4 Divorced "naturaf", Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical Lygnes. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Custodian <u>Balto. Co. Schools</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Ethel V. Lawrence ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thurman Sykes (Husband) 301 Farwind Drive, Apt. 1-B, Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/05/2007 Crest Lawn Cemetery Marriottsville, Md. 21 Signature of Furniral Spolice Lice 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A 23a. Part 1. Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Distriction of the death of the death of the death of the death of the death of the disease or condition resulting in death) 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death **Physician** /Medical e to (or as a consequence of Examiner mouna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 npatient ို 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death I Director: / d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

10

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year) 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Drive Baltimore

29d. Date signed (Month, Day, Year)

Maryland 21215-0036

JUNE28, 200

JORETHA Shepparo	Baltimore, Maryland 21
	1
	Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Doretha Sheppard 28 М 2007 0517 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 □ VF 74 597-50-6712 12-30-1932 Director N.C. Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f sh t be notified 1X Yes 2 No Md. NA Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 849 Exter Hall Street 21218 USA ns 23a must b Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. ıral", or iten Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☑ No Specify. Specify: Be Completed by 3 Widowed 4 Divorced "natural" 16a Decedent's Usual Occupation 16h Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Various llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental Kerney Sallie Greogre Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .03 permit. Pages 1 and:
Department of Health
Important: If item 27 i
any injury or other tra Daisy Darden Sister 6232 Cobblestore Rd., North Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cem. 6-30-07 Dundalk, Md. 21 Algnaure of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each experience of the complications are caused in the cause of Approximate Interval Between Onset and Death Immanue Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has le 2 s autopsy page certificate 1□ Yes 211No Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No PICE P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the for investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title o cause of death (Item 23a) (Type, Print) N- Charles Shalls Md 206 and address of person who complete \$2. Registrar's Signature 31. Date filed (Month, Day, State 2007 Registrar

		1 - State #1,23a,per D, 17 Registrar 1. Decedent's Name (First, Middle, Last			Hillicate Of		2. Date of De	Reg. No.	0 2 .	3. Time of Death
nysici		Theodore	^{t)} Theodore Set:	ren	Sotor	1	June	Day 2.3	Year 2.007	12:29 FM
Medio xamin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De		T- T-	ounty of Death	
		The Johns Hopk			Baltim	•				N/A
neral ector		5. Social Security Number 214-26-4431 Usual Residence of Decedent		76 Yrs.	Months Days	Hours Mi		931"	9. Birth	place (State or Foreign MD
Ħ		10a. State 10b. County	10c	City, Town or L	ocation				1	10d. Inside City Limits
	į	MD BALTIMO	DRE	BALTIMO)RE					1 ☐ Yes 2 🕅 No
9	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
TRAIL C	rail	904 DROPLEAF COUR			2120				U.S.A.	
event, the Medical Exercites the number of	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever if Armed Forces? 1 ☑ Yes 2 ☐ No K If Yes, Give Year or Dates: W		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		. Race - Americ Black, White, pecify:	
		15. Decedent's Edu	ucation	16a. Dece	edent's Usuaf Occu	pation		16b. Kind	of Business/In	
P. H. Waller	Completed	(Specify only highest grad	College (1-4or 5+)	PRINT	e kind of work done DO NOT use retire FER	during most of w d)	rorking	PR	INTING	
	Be (17. Father's Name (First, Middle, Last)		CETDO			ame (First, Middle,	Maiden Si		A C. I.
	၉	PHILLIP Settren		SETRO		BESSIE			BULM	
		19a. Informant's Name/Relationship (T) SONYA SETREN / WI	уре, Print) LFE		ing Address (Street					o Code)
		20a. Method of Disposition		b. Place of Disp	OROPLEAF Of Osition (Name of	I .	Date		tion - City or To	own, State
		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	-	omatory or other pla		25/2007	wood	LAWN, M	D
once.		21. Signature of Funeral Service Licens			22. Name and Addre					
once		Joen alan		8	3900 REIS	TERSTOWN	ROAD - I	PIKES'	VILLE,	MD 21208
		23a. Part1. Enter the disease, or composhock, or neart failure. List only of	lications that caused the c	lasth Danata					1	
	l i		one cause on each ime.	eath. Do not er	nter the mode of dyl	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
ш.		Immediate Cause (Finaf disease or condition			nter the mode of dyl			rrest,		Interval Between Onset and Death
al		Immediate Cause (Finaf disease or condition resulting in death)	a. Due to (or as a con	Sequence of):	nary en	nbolish		rrest,		Interval Between Onset and Death
ı	je.	disease or condition resulting in death)	a. Likely Due to (or as a con	oulmov sequence of): nous_t	nary en Inombosi	nbolisn s	1			Interval Between Onset and Death
al er	miner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Likely Due to (or as a con	oulmov sequence of): nous_t	nary en Inombosi	nbolisn s	1			Interval Between Onset and Death 20 minute
al er	Examiner	disease or condition resulting in death)	a. Likely Due to (or as a con	oulmoves sequence of): nons to sequence of): nable statements	nary en Inombosi	nbolisn s	1			Interval Between Onset and Death 20 minute
al er		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Likely Due to (or as a con Due to (or as a con Due to (or as a con Nyporroa)	oulmoves sequence of): nons to sequence of): nable statements	nary en Inombosi	nbolisn s	1			Interval Between Onset and Death 20 minute
al er	dicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Likely Due to (or as a con b. Due to (or as a con C. hyporroa Due to (or as a con d.	Sequence of): NONS + Sequence of): MAHC A sequence of):	nary en Inombosi	nbolisn s	1	+)		Interval Between Onset and Death 20 minute Unknown Unknown
ı	dicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d	sequence of): nons sequence of): nable s sequence of): gnancy Fetal death 3	namen hrombosi rate (In	nbolish s pus antic	1	+)		Interval Between Onset and Death 20 minute Unknown Unknown
ı	dicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d	sequence of): nons sequence of): nable s sequence of): gnancy Fetal death 3	nary en nrombosi rate (lu	nbolish s pus antic	1	+)	d. Date of deliv	Interval Between Onset and Death 20 minute Unknown Unknown
ıl	dicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d. Due to (or a	sequence of): NOWS + sequence of): NAMC + sequence of): gnancy etal death of death 5	nam en nrombosi rate (lun	nbolish	oaghlan	23	d. Date of delivi	Interval Between Onset and Death 20 minute Unknown Unknown
al er	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d. Due to (or a	sequence of): NOWS + sequence of): NAMC + sequence of): gnancy etal death of death 5	nam en nrombosi rate (lun	nbolish	oaghlan	23 obacco use	d. Date of delive Month	Interval Between Onset and Death 20 minute Unknown Unk
al er	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d. Due to (or a	sequence of): NOWS + sequence of): NAMC + sequence of): gnancy etal death of death 5	nam en nrombosi rate (lun	nbolish	23e. Did t	23 obacco use Yes 2 an	d. Date of deliving Month secontribute to the No 3 Protection Protection States and States and States are second protection.	Interval Between Onset and Death 20 minute Unknown Unknown Unknown ery Day Year the cause of death? bably 4 □Unknown
al	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d. Due to (or a	sequence of): NOWS + sequence of): NAMC + sequence of): gnancy etal death of death 5	nam en nrombosi rate (lun	nbolish	23e. Did t	23 obacco use Yes 2 an	d. Date of deliving Month secontribute to the No 3 Protection Protection States and States and States are second protection.	Interval Between Onset and Death 20 minute 20
al	Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	a. Likely Due to (or as a con b. Due to (or as a con C. Due to (or as a con d. Due to (or as a con d. Due to (or as a con d. Due to (or as a con d. Due to (or as a con or to the	sequence of): NOWS + sequence of): NAMC + sequence of): gnancy etal death of death 5	namen nombosi nate Clup Ectopic pregnanc Other (specify) underlying cause gri	y y y 26. Place of D	23e. Did t 1 24a. Was autoj	23 obacco use Yes 2 an Dirry Trans	d. Date of delivimenth contribute to the contri	Interval Between Onset and Death 20 minute Unknown Unknown Unknown Unknown Day Year Day Year Dably 4 Unknown Dopsy findings available impletion of cause of
al	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	a. Likely Due to (or as a con b. Due to (or as a con c. Due to (or as a con d. Due to (or a	sequence of): NOW T sequence of): NAMC S sequence of): sequence of): resulting in the of	namen nombosi rate (In) Decreption pregnanc Other (specify) underlying cause gri	y y y y y y 26. Place of D ner: 4 \(\text{Nursing} \)	23e. Did t 1 24a. Was auto perfc 1 Yes	obacco use Yes 2 an osy rmag 20 No one) dence 6 [d. Date of delivements of the contribute to the	Interval Between Onset and Death 20 minute 20
al	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con d. Due t	sequence of): NOW T sequence of): NAMC S sequence of): sequence of): resulting in the of	namen nombosi nate (In) Ectopic pregnanc Other (specify) underlying cause grant Other (specify) Other (specify) ont 3 DOA Other (specify) Other (spec	y y 26. Place of D ner: 4 Nursing ry at k?	23e. Did t 1 24a. Was auto perfo	obacco use Yes 2 an osy rmag 20 No one) dence 6 [d. Date of delivements of the contribute to the	Interval Between Onset and Death 20 minute 20
ıl	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con c. Due to (or as a con d. Due to (or as a con	Sequence of): NONS Sequence of): NANC Sequence of): Sequence	Drombosi Tate Cin City City City Control C	y y y y y y 26. Place of D ner: 4 \(\text{Nursing} \)	23e. Did t 1 24a. Was autoperfor 1 Yes Peath Check only of Home 5 Resi	obacco use yes 2 an obsy yes 2 dence 6 (how injury of	d. Date of deliving Month e contribute to the contribute of the c	Interval Between Onset and Death 20 minute 20
al er	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con d. Due t	sequence of): NONS Sequence of): NAMC Sequence of): Sequence	Drombosi Tate Cin City City City Control C	y y 26. Place of D ner: 4 Nursing ry at k?	23e. Did t 1 24a. Was autoperfor 1 Yes Peath Check only of Home 5 Resi	obacco use Yes 2 an obacco use Yes 2 An obacco use Ob	d. Date of deliving Month e contribute to the contribute of the c	Interval Between Onset and Death 20 minutes
er er	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con b. Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con d. Due to (sequence of): NONS sequence of): NANC sequence of): Sequence of): resulting in the of the second of the seco	Drom bosing the Clump of the Cl	y y y y y y y y y y y y y	23e. Did t 24a. Was auto perfic 1 Yes leath Check only of City or Tot	obacco use Yes 2 an system yes 2 An obacco use one) dence 6 [how injury of win, State)	d. Date of deliving Month contribute to the contribute of the con	Interval Between Onset and Death 20 minute 20
al	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con b. Due to (or as a con c. Due to (or as a con d. Due to (or as a con	sequence of): NONS sequence of): NANC sequence of): Sequence of): resulting in the of the second of the seco	Drom bosing the Clump of the Cl	y y y y y y y y y y y y y	23e. Did t 24a. Was auto perfic 1 Yes leath Check only of City or Tot	an psy mines? 2 No pre dence 6 (how injury of the win, State)	d. Date of deliving Month contribute to the contribute of the con	Interval Between Onset and Death 20 minute 20
er	edical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con b. Due to (or as a con c. Due to (or as a con d. Due to (or as a con	sequence of): NONS sequence of): NANC sequence of): Sequence of): resulting in the of the second of the seco	DAM EN Inom bosi Tate CIM City of the (specify) _ underlying cause granderlying cause	y y y y y y y y y y y y y	23e. Did t 24a. Was auto perfic 1 Yes leath Check only of City or Tot	an posy and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second	d. Date of deliving Month o contribute to the c	Interval Between Onset and Death 20 minute 20
completely filled in by the fundral director, page 2 should be detached for use as the buria-transit	Medical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con b. Due to (or as a con b. Due to (or as a con c. Due to (or as a con d. Due to (or as a con	sequence of): NONS sequence of): NONS sequence of): NONS sequence of): Sequence of): Paral death of death	Drom bosing the control of the coursed at the tenvestigation, in my case of the course	y y y y y y y y y y y y y	23e. Did t 1 24a. Was autoperformed to the coursed at the time.	an obacco use observed and obse	d. Date of deliving Month a contribute to the contribute of the c	Interval Between Onset and Death 20 minute 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Ma	•	epartment of H Certificate of I			Reg. No.	7 911.0
Physic /Med		1. Decedent's Name (First, Midd	dle, Last)		SCHLANGER		2. Date of De Month JUNE	27 2007	3. Time of Death 10:15 P M
Exami		4a. Facility Name (If not institution	-			r Location of Death		4c. County of Dea	
		HOSPICE OF BA 5. Social Security Number	LTIMORE GILCH	RISI CIR e (In yrs. last birth	day) If Under 1 Year	TOWSON If Under 24 Hrs.	8. Date of Bir	th 9.Birt	ALTIMORE thplace (State or Foreign buntry)
Funeral Director	•	087-28-3264	1 X 1M 2□ F 7	7 8 Yr	Months Davs	Hours Min.	(Month, Da 04/14/1	929 Co	NY
land w t		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City, Town	or Location				10d. Inside City Limits
Mary I-f sho fied a	to	MD HOWA	ARD .	COLUM	BIA				1 □Yes 2X No
th the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
23a cust b		5510 HILL FA			21045			U.S.A. 14. Race - Ame	adam Indian
III (Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ntal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11, Marital Status 1 □ Never Married 2X Ma 3 □ Widowed 4 □ Divorce	I If Yes, Give	Ever in U.S.	13. Was Decedent of HIf Yes, specify Cuba1 ☐ Yes 2 X No	ispanic Origin? (Span, Mexican, Puerto	o Rican, etc.)	Black, Whit	
72 hou	eted	15. Decede (Specify only high	ent's Education nest grade completed)	1 6	ecedent's Usual Occup Give kind of work done	during most of work	king	16b. Kind of Business	•
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	ife. DO NOT use retired	a)		SOCIAL SEC	CURITY ATION
INIBITY ISING ZIZID-UUSO Id 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam'	Be C	17. Father's Name (First, Middle	_				ne (First, Middle	, Maiden Surname)	
arylan should be ind Mental s marked o umatic eve	T	BERNARD			.ANGER	TILLIE		SILVE	
IOCE, INIALYIS ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relation			. •			per, City or Town, State,	•
C 24 14 2		CAROLYN SCHLAN 20a, Method of Disposition	IGER / WIFE		U HILL FAL Disposition (Name of crematory or other place		Date	20c. Location - City or	
F F F F		4 □ Donation 5 □ Other			A MEMORIAL 22. Name and Addre	07/01		COLUMBIA, N	
permit. Departr Importa any inje	6	21. Signature of Funeral Service Matt Lev	ng beg., masses		8900 REI	STERSTOWN	ROAD -	- PIKESVILLE	, MD 21208
Physician /Medica	_	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	ast only one cause on each II	ne.	hemator		or respiratory a	arrest,	Approximate Interval Between Onset and Death
Examine			Fa	LL Consequence of	,			0	weeks
	ner	Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se	a consequence of).	0,	2/5	4.	
ficate be executed in physician and is the burlat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	- 67	The	2 ,	
ficate be ex physician is the burial	短 田		d	, , , , , , , , , , , , , , , , , , , ,	,	and A	De I		_
	edical		u		0.000	NY N	K A		
Hecords, P.O. Box (The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	1 7	Ti	23d. Date of de Month	elivery Day Year
that the detac		Part II. Other significant cond		-		ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
quires quires in sign	ed by	DAVICE'S	no disease	, Dem	ntia		1 🗆	Yes 2⊠No 3□F	Probably 4 ☐Unknown
4) g 23 C/	Completed						perf	opsy prior to formed2 death?	autopsy findings available completion of cause of s 2 \sum No
VITA ician: Sertific ector,	Be	25. Was case referred to medi examiner?	Hospital:		Ott	26. Place of Dea		. "11	1/
on or olling Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident inve	28a. Date of Inju	<i>ay Year)</i> In	me of 28c. Inju	4 Li Nursing F	28d. Describe	e how injury occurred wheelchair	. ,
DIVISION OF VITAL HE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Coul	ld not be ermined 28e. Place of in building, e		m, street, factory, office		City or To	(Street and Number or Fown, State)	
Hospit 24 hour Funera tely fille		(O) 1 . 1 . 0	ying Physician: To the best al Examiner: On the basis of		/ ! ! ! ! ! ! ! ! ! ! ! ! ! !	and the same of a sale of a sale		a data and place and de	in to the course(c)
o the rithin 2 o the complete	Medical	29b. Signature and title of certi	and manner st	iaieu.	29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
F > F 8		IM Ant	hay Roly	, no	02	2901		June 22,	2007
5		30. Name and address of pers		death (Item 23a) (7 6701 /	Type, Print) V- Chule	St. B.	altr. 1	nd 2,20%	·
S Regis	tate	31. Date filed (Month, Day, Ye	ar) 32. Regist	ar's Signature	Couls				

	×	·	1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of Maryl		rtificate of		Reg	3. No. 2007	3. Time of Death
	Physici	an		st)				Month June 30	, 2007 Year	6:45 A ^M
1	/Medic		Joyce Ann Swann 4a. Facility Name (If not institution, giv	a street and number)		4h City Town	or Location of Death	Julie 30	4c. County of Death	
	Examir	ier	Manor Care	e street and number,		Catons			Baltimore	
	Funcani		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		place (State or Foreign intry)
h	Funeral Director			C7	73 Yrs.	Months Days	Hours Min.	(Month, Day,) 3/25/19	Vear) Cou 134 Vi	rginia
	yland		10a. State 10b. County		. City, Town or L	ocation				10d. Inside City Limits
:	Mar	ţ	MD Balti	more	Lansdo	wne				1 ☐ Yes 2X No
:	2 should be tiled within 72 hours atter deeth with the Maryland and Mental Hygiens, and Mental Hygiens, is marked other then "nature", or Itams 23s or 28s-1 show aumatic event, the Mastical Examble or must be notified at	Funeral Director	10e. Street and Number 2113 Smith Ave.			10f. Zip Code 2	1227	1 3	g. Citizen of What Cou U.S.A	intry?
	deeli	nerg	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of	Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
5	or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give				rican, etc.)	Black, White	
3	re!', o	þ	3 ☐ Widowed 4 X Divorced	Year or Dates:		1 ☐ Yes 2 🔀 No	<i>Зресну</i> :		Specify: Whi	te
ה ה	natu Hend	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during most of works ad)	ing 16	6b. Kind of Business/l	ndustry
Maryland 21215-0056	E 2 1	du	Elementary/Secondary (0-12)	College (1-4or 5+)			•		-	-
4	ygier ygier her ti	ဒ	9		Bu	siness O		(First Middle 14	glass sa	ites
	be ti tal H d otl	B	17. Father's Name (First, Middle, Last John M. Austin)			Elsie Wi	(First, Middle, Ma	aiden Sumame)	
7	Mer Marke Marke Marke	မ								
	2 sh and and ie m	N 18	19a. Informant's Name/Relationship (City or Town, State, Z	
ב וז	and leelt m 27 her t	1 2	Karen Link/Daugh			9 Woodfo		_	wville, MD	
5	permit. Pages 1 and 2 should be Department of Heelth and Menta important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3	Imemoval from State		osition (Name of matory or other pla	1	-		
	tant:		4 Donation 5 Other (Special	CONTRACTOR CONTRACTOR	The second second second	Company of the Compan		THE RESERVE OF THE PARTY OF THE	Elkridge,	
Dalumore,	Depermit Depermit Impor Impor Impor Impor		21. Signature of Funeral Service Lice	1589	Ğ	ary L. Ka	aut Man Fun	eral Hom	e @ MMP, I	inc.
	0 D = € 0		Jane for			250 Wash:	ington Bly	d. Elkr	idge. MD 2	1075
			23a. Part1. Enter the disease, or com shock, or heart failure. List only							Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	MET	TA STA	TIC	LUNG	CANC	ER	2 MONTH
	/Medical Examiner		resulting in death)	Due to (or as a cor						
	-xammer		Sequentially list conditions,	b	Α.					
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a cor	nsequence or):					
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a cor	sequence of):					
,	ate be executed nysician and he burial-transit	calE								
700	cate physic			_ d						
Y	death certificati attending phy for use as the	by Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of pr	egnancy	-			22d Date of deli	
YOU !	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetel death 3	☐Ectopic pregnanc☐ Other (specify)	У		23d. Date of deli- Month	Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	ordeath 5t	_ Other (specify) _				
Ľ	res that the de signed by the a be detached f	P	Part II. Other significant conditions	contributing to death but no	t resulting in the i	ınderivina cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
֟֝֟֝֟֝֟֝	sign d be	1 b			•	, ,		† √ Yes	2 □ No 3 □ Pro	bably 4 Dunknown
5	w require bean si should h	Completed				·				
ַ ע	has has	d L						24a. Was an autopsy performs	prior to c	topsy findings available ompletion of cause of
5	cete			PATE T. 1						2□ No
	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:	71 11	10	has .	Check only one		
5	this aldir	2	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatie	nt 3 DOA	4 Nursing Ho	me 5 Residen 28d. Describe how	nce 6 Other (Spec	ufy)
Division of Vital records,	After Funer	5	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yee	er) Injury	Wo	ork? Yes 2 \ No	ZOG. Describe nov	a injury occurred	
2	death death stor: the	Cat	2 Accident investigation 3 Suicide 6 Could not be	e One Olean of Injury	At home form of			28f Location (Stre	et and Number or Ru	ral Boute Number
2	affer Direction by	Certification:	4 ☐ Homicide determined	building, etc. (S)	pecify)	reet, ractory, ornce		City or Town,		iai rioute Number,
	To the Hospitel of Atlanding Prysician: The law frequires that the death certifica within 24 hours after death. within 24 hours after death. The Funestal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, pace 2 should be detached for use as the		(Check only 2 Medical Exa	nysician: To the best of my miner: On the basis of exa	r knowledge, dea mination and/or in	th occurred at the to	ime, date and place, opinion, death occurr	and due to the cau	use(s) and manner as	stated. to the cause(s)
	the f the f	Medical	one)	and manner stated.						
	5 W E 00	2	29b. Signature and title of certifies	10 100		2	ise number	290	d. Date signed (Month	7
•	1		, co	LE MU			6354		1/2/20	00/
	17		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	PA.	TIMANT	110 7	1229
			21 Date fled Attach Day Variation	174065		TION A	VE BAL	LINORE	MUZ	1201
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's S	orginal di B	and a				

07-04934 Travis Torain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

avis rotalii		1-For State Certificate of Death	
Physici edical Exami	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Vest	Time of Death 1653 hrs
elia.	1101	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		Union Memorial Hospital Baltimore N/A	
Funeral Director		218.22.5633 1 M 2 XF 83 Yrs. Months Days Hours Min. 04 07 1924 Foreign Country	ry) NC
ny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	0d. Inside City Limits
tnd show a	ř	MD N/A Baltimore 1	Yes 2 No
Maryla 28a-f	rect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	?
ith the 23a o	Funeral Director	57 E. 21St Stylet 21218 USA 11. Manital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American	o Indian Black
death w r items	nuer	1 Never Married 2 Married 2 Married 2 No Was Deceded to Hispanic Origin: (Specify Tes of No White, etc.) 1 Yes 2 No	Tillidian, Black,
s after ral", n	þ	3 Wildowed 4 Divorced in res, sive rear 1 Yes 2 No specify: Specify: Specify: DQC	
72 hour "natu	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indudring most of working life. DO NOT use retired)	
036 within ? ene. er than	Completed	12th grade N/A Housewife Domesti	IC
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Hygiene and Hygiene Aris I friem 27 is marketel other than "natural", nr items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	Be	Louis Wagstaff Mamie Wagstaff	
MD 2' and and Ma 27 is ma 27 is ma aumatic en	٦	19a. Informant's Nam. /R Jationship (Type, Print) Charles Toran / Son 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Address (Street and Number, City or Town, State, Zi 19c. Mailing Add	
ore, es l and of Heal If iten her tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Tor	
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other Specify: King Memoral Park 0705 07 Windsor M 22. Name and Address of Facility Vally Memoral Service Licensee 22. Name and Address of Facility Vally Memoral Service Licensee	ill, MD
Ba perm Depa Impe injur		1) Clyta Mo1343 4905 York Road Baltimore MD 212	u snas 12.
Physician /Medical		23a. Fart I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
vaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
	L	Sequentially list conditions,	
	Examiner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
cuted ind transit			
60, ate be exe physician a	Medical	UNPENDED AMENDED	
1876 rtificate ing phy as the b			y Year
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
P.O. Es that the cannot be detached	by Ph		
Records, P.O. I The law requires that the rate has been signed by the			
COrc law ret has be	Completed	248. Was an 240. West autopsy autopsy prior to compare the compared performed?	osy findings available appletion of cause of
l Re n: The tificate or, page			2 No
Vita hysicia this cer	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:	
Division of Vital Records, rate day require and the taw require and the taw require and the taw require. The taw require and the taw rectificate has been sided in by the funeral director, page 2 should the	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 No	
risio r Atten er deatl rector: 1 by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural	Route Number, City
Div pital or ours aft eral Di	Certification:	Suicide 6 Could not be determined (Specify) Suicide 6 Could not be determined (Specify)	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, page	Medical O		
F 3 F 8	Me		, Day, Year)
7		O.C.M.E. June 29, 2007	
10		30. Name and address of person who completed cluse of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S Regis	ate trar	III U A CUUI BEGAGARA A E.P. AMARAMA	-

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Olato of Marylo		tificate of	Death	, ,	leg. No.	7 17	ojini,
*	Physici	an	1. Decedent's Name (First, Middle, La	,			·	Date of Dea Month	Day	Year	3. Time of Death
1	/Medic	cal	Thomas_	Cheste	er	Tabr		June	30	2007	1:30p. ^M
	Examir	ier	4a. Facility Name (If not institution, given 3700 Fernhill	·		Baltim	Location of Death		4c. Co	unty of Death	
	Funeral	į.			rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth) ,, ,	9. Birth	place (State or Foreign intry)
d	Director		243-20-4974	¹XDM 2□F 82	Yrs.	Months Days	Hours Min.	04 16	25	Cou	NC
	w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	Manyla f sho	ō	MD NA		Baltim						1 XYes 2 No
	the 28a-	Director	10e. Street and Number		Darcin	10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
	h with	a D	3700 Fernhill	Ave		21	215			S.A.	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	1	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No-	14.	Race - Ameri Black, White,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		I∐Yes 2∏ No	Specify:	,,,			Black
Baltimore, Maryland 21215-0036	hour htural	ed b	15. Decedent's E		16a, Deced	lent's Usual Occup	ation		16b. Kind o	of Business/In	
215	hin 72 e. nn "ng Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done o OO NOT use retired	during most of work)	ing			
212	d with	Jom M	12th grade	na na	Main	tenance	Engine	er	Fede	eral (Government
nd	d d o	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I	Maiden Sur	name)	
<u>₹</u>		은	James Tabron		1		Matild				
<u>a</u>	12 ha 7 is	1	19a. Informant's Name/Relationship	,			and Number or Rura				
<u>ရ</u> ်	s 1 and 3 Health item 27 other tr		Ervin_Solomon= 20a. Method of Disposition			Sition (Name of natory or other place	y Road,			on - City or Te	21244 own, State
ē			1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Inemoval nom State		natory or other plac Memoria		07	Arhiit	us, N	40
<u>=</u>	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lice		22	. Name and Addres	s of Facility		11000	.057 1	14
n	De Im		Eterme It.	Thompson	JR. 43	rch F/H 00 Waba	west sh Ave,	Baltin	nore	Md	21215
			23a. Part . Enter the disease, or com shock, or heart failure. List only	iplications that caused the de one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Arthersch	enotic !	Carlisva	sculer D	isouse.			Onset and Death
	/Medical Examiner	Ш	resulting in death)	Due to (or as a cons							
b		e.	Sequentially list conditions,	b. Due to (or as a sons	equerios off.						
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	an and rial-tra	Еха	resulting in death) Last	Due to (or as a cons	equence of):						
98760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical		▲d							
	entifica ling ph e as t		IF FEMALE:								
ô n	leath ce attendir I for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg	etal death 3	Ectopic pregnancy			23d.	Date of delive	ery Day Year
л Э	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	rdeath 5_	Other (specify)					
	w requires that the de been signed by the s should be detached		Part II. Other significant conditions	contributing to death but not r	esulting in the ur	iderlying cause give	en in Part I.	23e. Did tot	bacco use o	contribute to t	the cause of death?
ital Kecords,	quires en sign uld be	ed by						1 □ Y€	es 2 🗐 🕅	o 3 □ Prol	bably 4 Unknown
ပ္တ	aw re Is bee 2 sho	plete						24a. Was a		4b. Were auto	opsy findings available
ř	The ate h	Completed						autops perforr 1 Yes	mod? 2 DNo	pnor to co death? 1 ☐ Yes	empletion of cause of 2 No
II.	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death				
0	is in di	ည	1 Yes 2 No		☐ ER/Outpatien		4 L Nursing Ho				fy)
חכ	ding Phys h. After this funeral dir	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ `	/at :? /es 2. □No	28d. Describe ho	ow injury oc	curred	
UIVISION	death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 28e Place of injuny . At	home, farm, stre			28f Location (St	reet and No	ımher or Run	al Route Number,
2	al or / after I Dire d in b	Certification:	4 Homicide determined	building, etc. (Spe		, ,		City or Town	n, State)	mber or man	a riodic framcon
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier 1 CertifyIng Pl	nysician: To the best of my k	nowledge, death	occurred at the tin	ne, date and place,	and due to the c	ause(s) and	manner as s	stated.
	the Hin 24 the Fu	Medical	oge) 2 medical exal	miner: On the basis of exami and manner stated.	mation and/or inv			ed at the time, d	ate and pla	ce, and due t	o the cause(s)
	To vit	Σ	29b. Signature and title of certifier	10-		29c. License				gned (Month,	Day, Year)
•	171		Largera .	we S		10005	53337		7-3-	-01	
-	400		30. Name and address of person who	completed cause of death (It	em 23a) (Type, F	Avenue ?	Bult	muve M	nd z	1209	
	Sta	te	31. Date filed (Month, Day, Year)	completed cause of death (Ith 2835) 32. Registrar's Sig	nature						
	Registr		JUL 0 3	2007 Marie	di de	ale					

	1.	For State Registrar	State of M	laryland	•	artment of H		nd Mer	, ,	ne . No.	107		.)
Physiciar		Decedent's Name (First, Middle,	Last)						Date of Death Month	Day	Year	3. Time of Death	
/Medica		Earl				10,00			1011	1	2007	04:30	А
Examine	4a	. Facility Name (If not institution,		1/	1/ /	4b. City, Town, o			71	4c. Cou	nty of Death		
	-	The Johns	Mopkins		,10.1	If Under 1 Year	If Under 2		7		2 (7)	1 (0)	
Funeral Director	5.	Social Security Number 243-20-5870	6. Sex 7. A 1,55tM 2 □ F	.ge (In yrs. Ia 8		Months Days	Hours	Min.	Date of Birth (Month, Day, Y		9. Birth	place (State or Foreigntry)	חן
	U	suat Residence of Decedent		83)			Ma	ay 12, 19	22		NCNC	_
yland	10	a. State 10b. County		10c. City,	Town or Lo							10d. Inside City Limit	s
a-f e	2	MD				Balti	imore					1 Tx Yes 2 □ N	0
OUGS the Maryland hours after death with the Maryland tural; or iteme 23a or 28a-f show at Examinar must be notified at	10	le. Street and Number 1755 E. Preston	Street			10f. Zip Code	21	.213	10g	. Citizen	of What Cou USA	ntry?	
offer death virileme 23e	11	. Marital Status	12. Was Deceden	t Ever in U.S	i. 13. V	Was Decedent of h	Hispanic Origi	in? (Specify	Yes or No-		Race - Ameri Black, White,		
5-UUSO 72 hours after dea nature!; or iteme	2	1 Never Married 2 Married 3 Widowed 4 Divorced]No	1	1 ☐ Yes 2 👿 No		,	, 0.0.,			an American	
within 72 hours ene. then "naturel",	Complete	15. Decedent' (Specify only highest Elementary/Secondary (0·12)	s Education grade completed) College (1-40	(5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16	b. Kind o	f Business/Ir	ndustry	
d will	<u> </u>	5	College (1-40	3+)		labore	5			С	onstruc	tion	
land lid be fill lentel H ked ott	D 17	'. Father's Name (First, Middle, L	_{ast)} unk				18. Mother	r's Name (Fi	rst, Middle, Ma	iden Sun	name) Un	k	
Mar nd 2 sho lith and 27 is m r treum		9a. Informant's Name/Relationsh Sherry Jones / D				ng Address (Street 5 E. Presto							
O	20	a. Method of Disposition		1 00	ace of Dispo	sition (Name of	1	Date			on - City or T		
Itimor it. Pages itment of items: If it		1 🛣 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		8		natory`or other pla orest Vet.		7/09/20	007 Os	ringe :	Mills i	Mary land	
Series and a serie	2	1. Signature of Funeral Service L		Gari		. Name and Addre	-		lie Fune				
g ggggg		1 min				638 N. Gi	Lmor Str	-				21217	
Physician	Ir	3a. Part1. Enter the disease, or shock, or heart failure. List on mediate Cause (Final isease or condition	complications that cause only one cause on each	ed the death.	Do not ent	er the mode of dyi	1		46% 3			Approximate Intervat Between Onset and Death	
/Medical Examiner per sicien and principlitansit principlitansit per sicien and principlitansit per sicien and per sicient and pe	S	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. — Due to (or a	s a conseque	Zsc.	hemic	Ca	andi	railar o myo	pri	thy	10 years	3
ate be nysicia he bur	<u> </u>		d.	s a consequ	ence or):					-			
Hecords, P.O. Box by	IF 2	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetat	death 3□	Ectopic pregnanc Other (specify)	у			23d.	Date of delive	rery Day Year	
that the ded by detact		art II. Other significant condition	ns contributing to death	but not resu	lting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	cco use o	contribute to	the cause of death?	
ecords, law requires t es been signe 2 should be	S S	Critic.	al port	'C 51	1000	15			1 X Yes	2 🗆 N	o 3∏Pro	bably 4 Unknow	m
The law requir	9	0206/	Enilars.	12	120	Fr. 1.0	12		24a. Was an	24	th Were aut	opsy lindings availab	te
He lav	-	/ = 1 = 1				1 7/14/			autopsy performe	d?	prior to co death?	ompletion of cause of	Ĭ
		5. Was case referred to medicat					26 Blace	of Dooth (C	1 ☐ Yes 2 ☐ heck only one)	No	1 🗆 Yes	2 □ No	
	0	examiner? 1 ☐ Yes 2 ☐ € € € €	Hospital: 1 🕱 Inpa	tient 2 🗆 E	B/Outpation	nt 3□ DOA Ot	hon		5 Residen	oo 6 🗆	Othor /Cross	4.1	
Phys g Phys er this eral di		7. Manner of Death	28a. Date of In		28b. Time of				Describe how			(y)	
Attending F attend		1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investig		ay rear)	Injury		rk?]Yes 2.⊟N	No					
UIVISION C teal or Attending P is after death. al Director: After I ed in by the funera		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Place of I	njury - At hor etc. (Specify)	ne, farm, str	eet, factory, office		281.	Location (Stre City or Town,	et and Ni State)	umber or Rur	al Route Number,	
Hoepi 4 hou Funer sely fill		9a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the best examiner: On the basis and manner:	of examinati	vledge, death on and/or in	n occurred at the ti vestigation, in my	me, date and opinion, death	d place, and h occurred a	due to the cau it the time, date	se(s) and and pla	manner as ce, and due	stated. to the cause(s)	
within 2 To the complet	2	9b. Signature and title of certifier				29c. Licen			290	l. Date si	gned (Month,	Day, Year)	
		Santash 1	mmen M	ed: 1	0 -+	Pi	5-0	00		1. 1.	1	7.000	
1	30). Name and address of person v	who completed cause of	death (Item	23a) (Type,	Print)				4.7		000/	
1		Santosh Oo	mmen, 6	00 1	Vorth	Wolfe	Stre	et 1	altim.	ure	Mary	land 212	87
State Begistra	7	1. Date filed (Month, Day, Year)	2 2007 San 32. Regis	trar's Signati	ure	Coste		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7:51 P M 26, 2007 June 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 □xF May 2, Pennsylvania 50 1957 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Harford Bel Air 10f, Zip Code 10g. Citizen of What Country? 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No Specify: Specify: White

Approximate Interval Between Onset and Death

ZDAYS

2 DAYS

Year

Day

Month

Physician Mary-Elissa Tomecek /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center 5. Social Security Number **Funeral** Director 215-76-2330 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Funeral Director Maryland 10e. Street and Number 730 Reedy Circle 11 Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education <u>Music Teacher</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Rose Parenti Peter Mimzey Fedas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey James Tomecek/Husband 730 Reedy Circle, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-28-07 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MCCOMAS Funeral Home, P.A. 23a. Part1. Inter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 50 West Broadway, Bel Air, Maryland 21014 Immediate Cause (Final Physician ESPILATORY disease or condition resulting in death) /Medical Uue to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner BREAST CANCER ETASTATIC Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 2 NO Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1XInpatient 2 ER/Outpatient 3 DOA o mecek, ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D263 44 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICIA (SURAY, M) VPPEL CHEATEAKE MEDICAL CENTER; BEL AIR MARYLAND

State Registrar

31. Date filed (Month, Day, Year)

3 2007

0

	•		e of Maryland / Depa	artment of Health and Martificate of Death		ne 0 0 7	21197
Physicia /Medic Examin Funeral Director	al	1. Decedent's Name (First, Middle, Last) CHARLES 4a. Facility Name (If not institution, give street and Coden Living Co. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death FREDEXICH If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Day Year 2 9 Death Frederic Frederic Gounty 9 Birthplat County	3. Time of Death 8:15 Am ck ce (State or Foreign
ary land 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or items 23a or 28a-f ehow umatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 1 If Yes 13 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complete)	Decedent Ever in U.S. d Forces? es 2 (1) No , Give or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 Yes 2 And Specify: dent's Usual Occupation kind of work done during most of work done of work do	pecify Yes or No- Decify Yes o	14. Race - American Black, White, etc Specify: Kind of Business/Industrial Sumame)	n Indian, c. hite sistry
Baltimore, Maper I and 2 permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other traesonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal for 4 Donation 5 Other (Specify) 21. Signatur of Fineral Service Licensee	Metro 22	TAM 1232 Mil	a-07 B	Location - City or Town	4 MD 18434 PA 44
760, le be executed //Medical Examiner le burial-transit	cal Examiner	Sequentially list conditions, b. Due cause. Enter Underlying Cause (Disease or injury that initiated events c.	FAIL URE to (or as a consequence of): Tem INAL to (or as a consequence of): to (or as a consequence of):	O THAIVET	or respiratory garess,	tr	Ap roximate nterval Between Onset and Death
Records, P.O. Box 68 The law requires that the death certificat tte has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown	regnant at time of death 5[Inknown	□Ectopic pregnancy □ Other (specify)	23a Did tahace	23d. Date of delivery Month D	Day Year
	Completed by	Part II. Other significant conditions contributing	to death out not resulting in the b	nuellying cause given in Parts.	1 Yes 24a. Was an autopsy performed; 1 Yes 2	2 No 3 Probab	
sion of anding Phy: ath. or: After this ne funeral d	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	1 Inpatient 2 ER/Outpatien Date of Injury Month, Day Year) Place of Injury - At home, farm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	and Number or Rural F	Route Number,
Divis To the Hospital or Att. within 24 hours affer de To the Funeral Direct completely filled in by the	Medical Ce	(Check only 2 Medical Examiner: On t	he basis of examination and/or in manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	rred at the time, date at 29d.	and place, and due to the Date signed (Month. Da	the cause(s) lay, Year)
Sta Registr		30. Name and address of person who completed SIBTE A KAZMI, MY 31. Date filed (Month, Day, Year)	cause of death (Item 23a) (Type, SIY TOW 32. Registrar's Signature	Print) House Aue Fr	REDERVICE	MD ZI-	701.

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of N	/laryland				ealth ai Death	nd M	, ,	ene	1	
1	4		Decedent's Name (First, Manner)	iddle, Last)							1	2. Date of Deat	1		3. Time of Death
1	Physici /Medio		Regina Eli	zabet	h Turner	-						Month 6/2	Day 5/2007	Year	8:00p ^M
	Examir	- 4	4a. Facility Name (If not instit					,		Location of	Death		4c. County	_	*
		シ 東	1101 St. Pau	I Stre	eet	uni	t 220			imore				N/	Α
a de	Funeral Director		5. Social Security Number 216–16–9534	6. Sex	7. /]M 2 X]F	Age (In yrs. Ii 84	as <i>t birthday)</i> Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth Month, Day 4/17/19	Year) 23	9. Birth Cou	place (State or Foreign ntry)
	pu ,		Usual Residence of Deceder			10a Cib	, Town or Lo								10d. Inside City Limits
	Maryla I shov	tor	MD 10a. State 10b. Co	N/A		roc. City		Ltim	ore						1 Yes 2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, Its Medical Examinatings Le notified at	Funeral Director	10e. Street and Number 1101 St.	Paul S	Street,	Unit 2	203	10f. Z	p Code	2120)2	10	og. Citizen of U	What Cou	ntry?
	er death	unera	11. Marital Status		12. Was Decede Armed Force	s?	S. 13. \	Was Dece f Yes, spi	edent of Hi ecify Cuba	spanic Origi n, Mexican,	n? (Spe Puerto F	cify Yes or No- Rican, etc.)		ce - Ameri ck, White,	can Indian, etc.
900	ours after	þ	1 ☐ Never Married 2 ☐ 3€CXWidowed 4 ☐ Divo		1 ☐ Yes 2X If Yes, Give Year or Date:			I □ Yes	XX No	Specify:			Specif	y: w]	nite
21215-0036	n 72 h	oletec	(Specify only h		e completed)		16a. Deced (Give life, L	lent's Usi kind of w	ual Occupa ork done d use retired	ation during most (of workir	ng	16b. Kind of B	usiness/lr	ndustry
	filed withi Hygiene. other than	Completed	Elementary/Secondary (0- 10		College (1-4c	or 5+)		Acc	count				Distri		on
land	should be fit and Mental Hy s marked oth umatic even	To Be	17. Father's Name (First, Mic Harry James		er							(First, Middle, M eth Mary		,	
Maryland	d 2 shouth and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Rela Elizabeth Lo	ionship (Ty)	_{ре, Print)} Furner/ D	aughte	19b. Mailir r 1101	g Addres	s (Street a	and Number 1 Stre	or Rura	Route Number, Unit 22	City or Town	State, Zi	o Code) re MD 21202
ore,	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once.		20a. Method of Disposition			20b. PI	ace of Dispo	sition (Na	me of	م ا	D	ate	20c. Location	City or T	
Baltimore,	permit. Pag Department Important: any injury once.		4 □Donation 5 □ Other 21. Signs to of Funeral Ser	r (Specify)		1405		. N. me a	nd Addres	s of Facility		-			
Ä	permi Depar Impor any ir			~	·			1501	Les .	ort A	veni	Fupera Le, Balt	1 Home	MD 2	1230
	Physician /Medical		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or <i>co</i> mpli List only or	ne cause on each	ed the death i line.	STAS	er the mo	B K	g, such as co	ardiac o	ANCER	est,		Approximate Interval Between Onset and Death
S.	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or	as a consequ	uence of):								
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examine	that initiated events resulting in death) Last		Due to (or	as a consequ	uence of):								
Box 68	leath certificate attending physic for use as the	0	IF FEMALE: 23b, Was decedent pregnan	2	3c. If yes, outcor								23d. Da	ate of deliv	very
	that the death led by the atter detached for	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ 10 9 ☐ Unknown		1□Live birth 4□Pregnant 9□ Unknowr	at time of de		JEctopic (pregnancy pecify)				Mo	onth	Day Year
rds, P.O.	w requires that i been signed by should be deta	ed by Ph	Part II. Other significant con	ditions cor	ntributing to death	n but not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did tob			the cause of death?
I Records,		Completed by Physician/M										24a. Was a autops perform	y ned?	Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vital	ilcian: The certificate rector, pag	Be	25. Was case referred to me examiner?									(Check only on			
of \	Physician: this certific ral director,	ု	1 ☐ Yes 2 ☐ No	-	lospital: 1 ☐ Inpa		ER/Outpatien					ne 5 Heside			ify)
ion	Attending Production of death. Sctor: Alter to the funeral of the	tion:	27. Manner of Death 1 Natural 5 Per 2 Accident	ending restigation	28a. Date of li (Month, i	njury Day Year)	28b. Time of Injury	М	28c. Injun Worl	/at <br Yes 2 □ N		28d. Describe ho	w injury occur	rred	
Division	Dir	Certification:	3 ☐ Suicide 6 ☐ C	termined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, str	eet, facto	ry, office		2	28f. Location (St. City or Town		ber or Rui	ral Route Number,
	the Hospital nin 24 hours the Funeral npletely filled	Medical C			sician: To the be ner: On the basis and manner	of examinat									
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of ce	rtifier				25	c. Licens	e number		2	9d. Date signe	ed (Month	Day, Year)
	F 5 F 0		> PIN	Ari	is M)			01	479	34	5	TUNG	27,	2007
3) 4		30. Name and address of pe	son who co	mpleted cause o	of death (Item	23a) (Type,	Print)	- 01	ALE	RA	OMTO	LE M	12	4202
1	Sta Regist		31. Date filed (Month, Day	3 200	7 Z Regi	strar's Signa	ture do	NE.	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vest Physician Subramanian GIr 145am Malauakumar -22 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner () enter Baltimore Baltmore, ru If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 D F MIA Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or itama 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD timore more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 110 SA -12 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: ASKAN 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hyant: If Itam 27 Is marked oth Be Subramanian Deva Deepalatha Uboryakumar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St, Baltimore MD 110 W. 39th Deepalatha Subramanian / Mother 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. Injury or Pathedral 4 □ Donation 5 □ Other (Specify) Cometen 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradlen 2134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): maturity /Medical Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offattending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death ed by the a cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate has 2 No 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending investigation death. 2 No 2 Accident s after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D05894 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) St. Bultimure IND, 21201 (Dr. K 301 Mercy Medical Center 32 Registrar's Signature State JUL 0 3 2007 Registrar

		_	For State	State of M	laryland		artment of H		and Me	ental Hy	giene			
			Registrar 1. Decedent's Name (First, Middle	a Lanti		Cei	lilicate of i	Dealii		2. Date of De	Reg. No.		3. Time of	Death
	Physicia			3, Last)				-		Month	Day			M
	/Medic	- 0	Annabelle 4a. Facility Name (If not institution	a give street and number	F. –		von Gai			July		2007 County of Death	2:15	P "
	Examin	er			,							arroll		
	Funaral		Carroll Hospi 5. Social Security Number	6. Sex 7. A	ge (In yrs. la	st birthday)	Westm If Under 1 Year	If Under	24 Hrs.	8. Date of Bin	th	9. Birth	place (State	or Foreign
	Funeral Director		034-26-1178	1□ M 2√xF	71	Yrs.	Months Days	Hours	Min.	(Month, Da May 7		Mass	achuse	etts
	D		Usual Residence of Decedent		T									
	how	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside C 1 ☐ Yes	2√2 No
	Ba-f	cto	MD Carro)11	Syk	esvil					10- 011			- K
	or 2	Director	10e. Street and Number				10f. Zip Code				iog. Citiz	zen of What Cou	ntry ?	
	ath v	rai	7400 Village	Road	t Francis II C	12		1784	igin2 (Spe	offy Vas or No		US 14. Race - Ameri	can Indian	
	er de Item	Funerai	11. Marital Status 1 □ Never Married 2 □ Marri	Armed Forces	?	. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexicar	n, Puerto F	Rican, etc.)		8lack, White		
36	irs aft	by	3 ₩ Widowed 4 Divorced	If Yes Give			1 ☐ Yes 2 🔀 No	Specify:	•			Specify:	White	
21215-0036	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ehow coloul Experimential be notified at	Completed by		nt's Education		16a. Dece	dent's Usual Occup	pation			16b. Kii	nd of Business/Ir	ndustry	
215	within 73 ene. then "n	ple	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or	r 5+)	life.	kind of work done DO NOT use retired	au <i>ring</i> mos d)	it or workin	ig				
21	e filed within al Hygiene. other then '	Com	10			Care	giver	r—————			L	sing Hom	ie	
	be filed within 72 hours after death with the Marylar is Hygione. Ide Hygione. Ide other than "natural", or Itema 23a or 28a-1 show other than "natural", or Itema 23a or 28a-1 show event, Ite Madical Examinational be notified at	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
Va	should be and Mental marked umatic ev	၉	Henry Buri	cell					eresa				nown)	
Maryland	ges 1 and 2 should t of Health and Mer if Item 27 te marke or other traumatic		19a. fnformant's Name/Relations	hip (Type, Print)	2000		ng Address (Street					r Town, State, Zi 21157	p Code)	
-	and lealth m 27 her to		Posettary Ogla	a daug	hter		Muller Ro	Sau, V		TIP CET		cation - City or T	own State	
O.	Pages 1 ar nent of Hea int: If Item iry or othe		1 Burial 2 Cremation	3 ☐Removal from Stat	e ce	metery, cre	matory or other pla	. 1		2007				
Baltimore,	t. Pag tment ttant: I		4 □Doration 5 □ Other (S		Sale		Cemeter	_				stminste		
Bal	permit. Page Department Important: If eny Injury o		21. Signature of Funeral Service	Conservation of the conser	/		2. Name and Addre							
	1000		23a Part1 Errer the disease o	r complications that calls	ed the death.		12 W. Old					iera* ar	Approxima	te
			23a. Part1. Enter the disease, o shock, of heart failure. List Immediate Gause (Final	only one cause on sch				•					Interval Be Onset and	Death
	Pnysician /Medical		disea or ondition resulting death)	a	neu as a conseque	Mo	Mg.					-	ern.	
	Examiner		42000	Due to (or a	Soh	CIC.								
	* * *	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a conseque	enc o):								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	S . (90C	7								
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or a	as a consequ)			N ,				
8760,	e ys	ical		d	tcul	ie f	Lespine	tay	10	illure				
9	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:					-						
Вох	eath certific attending pl	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal	death 3[Ectopic pregnanc	у				 Date of deliment Month 	very Day	Year
0.		sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknown		ath 5	Other (specify) _							
<u>G</u> .	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditi	ions contributing to death	but not resu	Iting in the u	inderiving cause giv	ven in Part	1,	23e. Did	tobacco u	ise contribute to	the cause of	death?
Records,	signe bed b	d b		•		•	, ,			180	19s 2	□No 3□Pro	bably 4	Unknown
Ö	w requir been si should	Completed								24a. Was	an	24b. Were au	toosy finding	s available
Rec	The tav	m								auto perf	psy ormed?	prior to death?	ompletion of	cause of
ā		ပိ	25. Was case referred to medical	al				26 Plac	e of Death	1 ☐ Yes (Check only	2 L No	1 Tes	2 🗌 No	
Vital	Physician: this certificated fral director,	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospitaf: 1 Dinba	atient 2 🗆 8	ER/Outpatie	nt 3 DOA Ot	her				6 ☐Other (Spec	ify)	-
of		i.	27. Manner of Death	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o		iry at	- 1	28d. Describe	how inju	ry occurred		
Ö	Attending Is death.	atio	Z L Accident	tigation	, , , ,	,2.,]Yes 2□]No					
Division	l or Atte after de Directo	Certification:	3 Suicide 6 Could 4 Homicide determ	mined 286. Place of	Injury - At horests. (Specify		reet, factory, office			28f. Location City or To		nd Number or Ru e)	ral Route Nu	mber,
0	ital or irs afte ral Dir						-							
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medica	ing Physician: To the be I Examiner: On the basis	of examinat	wledge, dea ion and/or i	th occurred at the to rivestigation, in my	ime, date a opinion, de	nd place, a ath occurr	and due to the ed at the time	cause(s) , date and) and manner as d place, and due	to the cause	(s)
	thin 2 the mplel	Med	29b. Signature and the of portific	and manner	Stated.		29c. Licen	se number			29d. Da	te signed (Monti	n, Day, Year)	
	To To			QINCLE	L M	0	1 -	005	421	8	07	-02-	07	
•			30. Name and address of person	who completed cause of	f death (Item	23a) (Tyne	Print) -			0				
10			DR RAWEY	B. Kan	eva !	349/	Print) Paleol	m d	uve,	. wen	Lucin	ester MD	2115	7
	. ⊕ ¥ Sta	ate	31. Date filed (Month, Day, Year		strar's Signat		·							1
4	Regist		HH 0 3	2007 196	w K.	do	(E)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	of Maryland	•	rtment of H		•	giene Reg. No. 🤉 🏳	2	211.11
	Physicia	an	1. Decedent's Name (First, Middle						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Haralampos 4a. Facility Name (If not institution				4b. City, Town, or	Location of Deat		29, 20 4c. County		21:00P ^M
7	Examin	er	Montgomery (a 1	01ney			Mont	gome	ry
	Funeral		5. Social Security Number	6. Sex № M 2 □ F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th		lace (State or Foreign
6	Director		579-74-7844 Usual Residence of Decedent	FE IVI ZU!	67	Yrs.			10-13	-1939_		Greece
land	at at		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
Man	a-f sh iffied	ctor	MD Mont	tgomery	T.	Vheat	on					1 □Yes 2 No
ith the	or 28 se not	Dire	10e. Street and Number	C +			10f. Zip Code			10g. Citizen of	What Cour	itry?
eath w	is 23a must	eral	11906 Ivahar		edent Ever in U.S	13. V	20902	spanic Origin? (S	Specify Yes or No	USA - 14. Rad	ce - Americ	an Indian,
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marriad 3 □ Widowed 4 ☒ Divorced	ried Armed Fr 1 ☐ Yes If Yes, G	orces? 2]∑ No ive		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2☐MNo		to Rican, etc.)		ck, White,	
5-UU35 72 hours af	atural cal Ex	ted to	15. Deceden	nt's Education	- 1	16a. Deced	lent's Usual Occupa	ation	alain a	16b. Kind of B	usiness/Ind	dustry
מוק קיין	e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College ((1-4or 5+)		kind of work done o		rking			
7 8	lygien her th it, the			1		Se	1f-Emp1c		me (First, Middle	Resta		t
yland ould be file	ed otl	Be	17. Father's Name (<i>First, Middle,</i> Archimides Va						a Unkn		noj	
ary is	nd Me mark imatic	ဍ	19a. Informant's Name/Relations	ship (Type. Ppint)	sonal	19b. Mailin	g Address (Street a				, State, Zip	Code)
Mal and 2 st	alth a	1	19a. Informant's Name/Relations Vasiliki Vati	ista-Rep	•	119	06 Ivaha	ar St.	Wheat	on, MD	209	0.2
ore,	of He fitem or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State 20b. Pl	emetery, crer	natory or other plac	e) ;				
Saitimor	tment tant: jury c		4 □ Donation 5 □ Other (5	Specify)	0 a		vn Cemet				timo	re, MD
Dan Dan	Depar Impor any Ir		21. Signature of Funeral Service	LA	}	P	A 2134 er the mode of dyin	Br Willow	adley-	Ashton Road	Fun	eral Home,
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one caus	caused the death ach line.	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	_ab	laddel	LC0	meen					
	Medical xaminer	ш	Todaming in deading	Due to	(or as a consequ	ence of):						
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or se a nonsequ	ence of):						
petition	nd transit	Examiner	Cause. Chief Olderlying Cause (Disease or injury that initiated events resulting in death) Last	c								
X 68 / 60, certificate be executed	hysician and the burial-transit		resulting in death) Last	Due to	(or as a consequ	ence ot):						
587	physi s the l	edical		d								
BOX (attending p	II/M	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna birth 2 ☐ Fetal		Ectopic pregnancy	,			ate of deliv	,
_ • _ <u>c</u>	he atte	Physician/Med	in the past 12 montfis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Other (specify)			M	onth	Day Year
7. ½	signed by the a		Part II. Other significant condit	ions contributing to	death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
Hecords, P	n signe	d by							1 🗆	Yes 2 No	Pro	bably 4 □Unknown
000	as been sig	Completed							24a. Was			opsy findings available ompletion of cause of
		E CO								ormed?	death? 1 □ Yes	2 □ No
Vital	certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital: -			ot 317 DOA Oth	or:	eath Check onl	100		
Vision or Vita	h. After this of funeral dir	은	1 Yes No 27, Manner of eath	28a. Date	e of Injury	28b. Time o	1 3 DOX	4 Li Nursing	Home 5 ☐ Res 28d. Describe	idence 6 □Ot how injury occu		fy)
ion a	rth. r: Afte e fune	tion	Natural 5 Pendi 2 Accident invest	ing (Mo tigation	onth, Day Year)	Injury		k? Yes 2 □ No				
Division	within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 200. Flat	ce of injury - At ho ding, etc. (Specify		eet, factory, office			(Street and Num wn, State)	ber or Rur	al Route Number,
D the Hospital	nours a			ing Physician: To th								
H off	iin 24 I the Fu	Medical	one)		nner stated.	tion and/or in			curred at the time			
Ę	To To	Σ	29b. Signature and title of certific	er KD			29c. Licens		r	29d. Date sign	ear (Month,	Day, rear)
, 1	1		30. Name and address of person	u who completed car	use of death (Item	23a) (Type,	Print) N	1.1. x	2	10/2	111	7.00(3:-
4	N		MUHWW F	supples	Registrar's Signa	014	MUCP P	MID DI	MUP C	luey	MO	20852
	Sta Regist	ate rar	.1111	3 2007	Andrew .	K A	mark 1	1		•		

		For State Registrar		State C	n Maryia		artment of F rtificate of I		лептагту	Reg. No.	2007	1) [1]
46.5.0		Decedent's Name	e (First, Middle,	Last)					2. Date of De	eath Day	Year	3. Time of Death
Physicia /Medic	al .		Virginia						JUNE			5:10 A M
Examin	er	4a. Facility Name (I				1 Amsterio		r Location of Death BURNIE			County of Deat トCOUNT	
		BALTINO 6 5. Social Security N		HING-TON 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			thplace (State or Foreign ountry)
Funeral Director		216-28-	-2710	1 □ M 2 🔀 F		75 Yrs.	Months Days	Hours Min.	Oct. 2	6, 19	31 MD	
200		Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or Le	ocation					10d. Inside City Limits
faryla shov ed at	ō	MD		Arundel		en Burn						1 □ Yes 2x No
h the Maryland or 28a-f show o notified at	Director	10e. Street and Nu				on Burn	10f. Zip Code	·		10g. Citiz	zen of What Co	ountry?
death with		634 New	Jersey	Ave.			21060			USĄ		
r dea	Funeral	11. Marital Status		Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	 Race - Ame Black, Whit 	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Marr 3 ☐ Widowed		ed 1 ∐ Yes If Yes, G Year or I	2√√No ive Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify: W	hite
2 hou	ted		15. Decedent	s Education	1	16a. Dece	edent's Usual Occup	pation	kina	16b. Kir	nd of Business	/Industry
be filed within 72 hortal Hygiene. id other than "natueevent, the Medical	Completed	Elementary/Seco		t grade completed, College	(1-4or 5+)		e kind of work done DO NOT use retire	d)	9	g	6.37	1 1
filed withi Hygiene. ther thar tht, the M	S	17. Father's Name	9 (Eirst Middle I	act)		Cler	K	18. Mother's Nan	ne (First, Middle			aryland
d be fi	o Be	Fred Seet		-401/				Hazel H	a11			
should ind Mer marke	F	19a. Informant's N		ip (Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ıral Route Num	ber, City o	r Town, State,	Zip Code)
s 1 and 2 should be filed f Heath and Mental Hygi item 27 is marked other other traumatic event, t		Mr. Paul	Vojik/	Husband		634 N	ew Jersey	Ave.; G				
Pages 1: nent of He int: If iten iny or oth		20a. Method of Dis 1 ☑ Burial 2		Removal from	20b n State	o. Place of Disp ce <i>metery</i> , cre	osition (Name of ematory or other pla	Ju	1y 2,		cation - City or	
t. Pag rtmen rtant:		4 ☐ Donation 21. Signature of	5 D Other (%)	Secify)	G.		en Mem. I	eark 2	007 1		n Burniond Ave	
permit. Pages 1 an Der artment of Heal Important: If item 2 any injury or other once.		21. Signature of	Ar Service	_icerisee	MO1			-	Home: G			MD 21061
- 8		23a. Part1. Enter	the diffease, or	complications that only one cause on	caused the de		nter the mode of dyi					Approximate Interval Between
Physician		Immediate Cause	(Final on	Min	lesi	rea	d me	tasti	itie	em	cer	Onset and Death
/Medical Examiner		resulting in death)		Due to	o (of) as a cons	sequence of):		To but	Tholod	usy	lever	mont
E.Xuiiiiioi	ē.	Sequentially list co	onditions,	b. CC	Cor en e nuns	UUU	(CINY)	ra, -	pan	ca	las	overzn
uted d ansit	Examiner	Sequentially list contains to it cause. Enter Und Cause (Disease of that initiated events)	lerlying r injury ts	c								
e exec		resulting in death)	Last	Due to	o (or as a cons	equence of):						
ficate be executed physician and s the burial-transit	edical			d								
	/Me	IF FEMALE:	nt prognant		utcome pf pre				- 10=		23d. Date of de	elivery
death certif attending d for use a	ician	23b. Was decede in the past 13 1 \(\sum Yes \) 2	nt pregnant 2 months?	4□Pre	e birth 2□F gnant at time o		☐Ectopic pregnand☐Other (specify) _	cy			Month	Day Year
t the o	Physician/M	9 Unknow	7	9□Unk								to the access of double?
Attending Physician: The law requires that the death certingent. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by	Part II. Other sign	ificant condition	ons contributing to	death but not a	43	underlying cause gi	oven in Part I.	1	**	,	to the cause of death? Probably 4 □Unknown
requii been s hould	Completed	11/10		Mg I	cero"	0010	Lat , e		24a. Wa	<	_	autopsy findings available
ne law has b	mple								au	topsy rformed?	prior to death?	completion of cause of
sician: Th certificate rector, pag		25. Was case refe	erred to medica	ı				26. Place of De	ath (Check only		YYe	es 2 No
Physicia this cerral direct	To Be	examiner? 1 ☐ Yes 27	≫	Hospital:	Inpatient 2	2 ☐ ER/Outpati	ent 3 DOA OI	ther: 4 \sum Nursing I	Home 5□Re	sidence	6 □Other (Sp	pecify)
ng Ph offer th		27. Manner of Dea	5 Pendir	g (M	te of Injury onth, Day Year	28b. Time r) Injury	/ Wo	ork?	28d. Describ	e how inju	ry occurred	
ttendi Jeath. Stor: A	cati	2 Accident	investi 6	not be 28e Pla	ce of injury - A	at home, farm, s	M 1 5 street, factory, office]Yes 2 □ No	28f. Location	(Street ar	nd Number or I	Rural Route Number,
after of Direct of July by	Certification:	4 Homicide	determ	bui	lding, etc. (Sp	ecify)			City or 1	Tòwn, State	e)	
To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only	1 Certifyin	ng Physician: To t	he best of my	knowledge, de	ath occurred at the investigation, in my	time, date and plac	ce, and due to the	he cause(s ne. date an	and manner	as stated. ue to the cause(s)
the Ho lin 24 the Fu	Medical	one)	Z Medical	and m	anner stated.	milation and or	200 Linor	aca number	Janoa at the th	20d Da	ate signed (Mo	oth Day Year)
With Conf	2	29b. Signature an	nd title of certifie	115	nm)	(1)	250. Licer	10 Turiber	61	1	Adm 1 7	28.2Wd°
		30. Namo and ad	dress of person	who completed as	ause of death (Item 23a) (Tvp	e, Print)	0150	-6	1	vn u e	3,-0,
10		ALONSO B	BEENARI	WNB, M.D.	300 HD	SPITAL L	RIVE GER	BURNIE	HARYLA	ND C	21061	nih, Day, Year) 28, ZVO
	ate	31. Date filed (Mo	onth, Day, Year,	2007	. Registrar's Si	ignature 60	arte					
Regist	rar	U	IOF A B	1		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:03PM Rudolph. Williams 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Maryland Medical Center University of 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days M 2□F Director 18 NC 238-72-9312 58 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-s show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 🗀 No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U • S • A • 4. Race - American Indian, Highway Apt 1508

12. Was Decedent Ever in U.S. Armed Forces? 20910 Funeral 1215 East West Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2💢 No Saltimore, Maryland 21215-0036 Specify Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4or 5+) 5yrs+ Director of Admissions 12th grade Med. School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Eugine Mercer Russell Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. 55 Valley Forge Rd, New Castle, DE 19720 Shedred Williams-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 7/7/2007 Mercer Family Camden, NC Agnature of Funeral Service/Licensee 22. Name and Address of Facility
March F/H West None Shompson. JR 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Je15.5 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisaas 3 injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): P.O. Box 68760, inding physician ause as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cardiomyopath Nonischemic peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has le 2 autopsy page performed? certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
Completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, 2007 P19729 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

HEPP

2007

03

31. Date filed (Month, Day, Year)

21201

South Greene Street, Baltmore, Maryland

32 Registrar's Signature

			For Amend Item 2		Cer	uncate of i	Death	Re	g. No.	
74	n # 2		Decedent's Name (First, Middle, Las	t)			2	Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Richard		L	villia	ms !	May	13 2007	1:16 AM
	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death	١	4c. County of Death	
<i>y</i>			Johns Hopk	sins Hos	Pital	If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	NA 0 Birth	place (Ctate or Foreign
	Funeral		5. Social Security Number 6. S	ex 7.Age MXM2□F	(Ih yrs. last birthday) 61 Yrs.	Months Days	Hours Min.	(Month, Day, 6-16-	Year) 9. Birth	place (State or Foreign ntry) Md.
'n	Director	-	219-40-1604 Usual Residence of Decedent		OI .			0-10-	1343	na.
	land ow	Ì	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary	ţō	Md. N	A	Bal	timore				1 X Yes 2 □ No
	r 28a r noti	Director	10e. Street and Number			10f. Zip Code	7	10	g. Citizen of What Cou	ntry?
	h with	a D	336 S. Dallas	Ct.		2123	1		USA	
	ems :	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	Ispanic Origin? (Specian, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White	
õ	or its		1 Never Married 2 Married	1 ☐ Yes Y ☐ No If Yes, Give	0	1 □ Yes 2 ☑ No	Specify:		Specify: R	lack
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dacer	dent's Usual Occup	ation	1	6b. Kind of Business/li	
7	"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done	during most of working d)	' I	ob. Mila of Basinosan	.aac.ry
7	withii ene. than he M	ЩC	Elementary/Secondary (0-12)	College (1-4or 5+	-)	oisabled			NA	
and 2	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, M	,	
<u>a</u>	uld be Mental Irked o	To B	James	н.	Willia	ams	Lorria	ne	Wil	liams
Mary	shou and N s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rural	Route Number,	City or Town, State, Zi	p Code)
_	and 2 alth a 127 Is		Louise William	s Ex-Wife					ltimore,	
e e	es 1 and the solution of the ritems roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romoval from State	20b. Place of Dispo cemetery, crei				Oc. Location - City or T	
Ĕ	nit. Pages artment of ortant: If it Injury or o		4 □ Donation 5 □ Other (Specif	y)	King N	Mem. Pk.	5-19	-07	Randalls	town, Md.
Baltimore,	permit. Departr Importa any Inj	į	21. Signature of Funeral Service Licer	wan		2. Name and Addre	. 141	arch F e., Ba	.H. East ltimore,	Md. 21202
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	the death. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final	A	Nasopha	ryngeal (ancer with	ı Compli	ications	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of)	05547	00 17011			In uno
	Examiner			Freches	stomy to	160 Dis	Colgenca	+	11	wind tos
Ĺ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):				11 the	il .
3	cuted	Examiner	Cause (Disease or injury that initiated events	c. Hacke	estury	5. te 6	Lection	fre	ICAL EXAMINE	Minutes
Š.	ificate be executed g physician and as the burial-transit	Ě	resulting in death) Last	Due to (or as a	consequence of):	1	Th	APPROVED BY ME	,,-	i
68760,	ate hy:	edical		d. 10 +41	LOIGNO	10000	TEICATION A	Ph.		1 year
_	ertifica ding ph		IF FEMALE:	23c. If yes, outcome p	of pregnancy	·	CEKI			107/
P.O. Box	leath certi attending f for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	2 ☐ Fetal death 3 ☐	☐Ectopic pregnanc	У		23d. Date of deliment	Day Year
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐Unknown	anie or dedair - OE					
٦.	res that the de signed by the s be detached t		Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
an.	uires sign ld be	d by	Nosopherge	yeal to	ZICINON	4-		1 D Ye	s 2□No 3□Pro	obably 4 □Unknown
Ġ,		te								
cords,	w rec	<u>-</u>						24a. Was ar	24b. Were au	topsy findings available
Records,	'he law require e has been sig age 2 should b	omple						autops: perforn	y prior to o	ompletion of cause of
tal Records,	The la te has	e Completed	25. Was case referred to medical				26. Place of Death	autops perforn 1□ Yes 2	y prior to death? Death of the prior to death? Death of the prior to death? Death of the prior to death?	topsy findings available ompletion of cause of
· Vital Records,	ysician: The law rer is certificate has bee director, page 2 shoi	Be	25. Was case referred to medical examprer? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatier	nt 2 DER/Outpatie	nt 3□ DOA Oth	26. Place of Death ner: 4□ Nursing Hom	autops perform 1 Yes 2	y prior to death? Death of the prior to death? Death of the prior to death? Death of the prior to death?	2 PNo
ι or Vital Records,	ysician: is certifice director, p	To Be	examiner? 1	28a. Date of Injur	y 28b. Time o	IL 3 DOA	ner: 4 Nursing Hom	autops perforn 1 Yes 2 (Check only one e 5 Reside	y prior to death? death? 1 □ Yes	2 PNo
sion or Vital Records,	ysician: is certifice director, p	To Be	examprer? 1 2	28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Inju	ner: 4 Nursing Hom	autops perforn 1 Yes 2 (Check only one e 5 Reside	prior to death? No 1 Yes Once 6 Other (Spec	2 PNo
ivision or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	To Be	examirer? 1	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	of 28c. Inju	er: 4 Nursing Hom ry at 2: rk? Yes 2 No	autops: perform 1 Yes 2 (Check only one e 5 Reside Bd. Describe ho	prior to cleath? death? 1	ompletion of cause of 2 12 No
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	Certification: To Be	examprer? 1	28a. Date of Injur (Month, Day e 28e. Place of injur building, etc	y Year) 28b. Time of Injury rry - At home, farm, st. (Specify)	of 28c. Inju Wo M 1 Treet, factory, office	ier: 4 Nursing Hom ry at 2 k? Yes 2 No 2	autops: perform 1 Yes 2 (Check only one 5 Reside Bd. Describe ho Bf. Location (Sti	prior to death? death? 1 □ Yes Death? 1 □ Yes Death? 1 □ Yes Death? 1 □ Yes Death? 2 Death? 2 Death? 2 Death? 3 Death? 4 Death. 4 Death	ompletion of cause of 2 PNo ify) ral Route Number,
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	Certification: To Be	examijver? 1	28a. Date of Injur (Month, Day nee 28e. Place of injur building, etc	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deat examination and/or in	of 28c. Inju Wo M 1 Creet, factory, office	ier: 4 Nursing Hom ry at	autops: perform 1 Yes 2 (Check only one e 5 Reside 3d. Describe ho 3f. Location (Str. City or Town	prior to death? 1 Ves a) nce 6 Other (Spector winjury occurred reet and Number or Ru , State) ause(s) and manner as	ompletion of cause of 2 12 No iffy) ral Route Number, stated.
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	To Be	examprer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio 2 Accident 3 Suicide 6 Could not b determined	28a. Date of Injur (Month, Day e 28e. Place of injur building, etc	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deat examination and/or in	of 28c. Inju Wo M 1 Creet, factory, office	ier: 4 Nursing Hom ry at k? Yes 2 No 2i me, date and place, a opinion, death occurre	autops: perform 1 Yes 2 (Check only one e 5 Reside 3d. Describe ho 3f. Location (Str City or Town and due to the ca d at the time, di	prior to death? 1 Ves a) nce 6 Other (Spector winjury occurred reet and Number or Ru , State) ause(s) and manner as	ompletion of cause of 2 12 No rai Route Number, stated. to the cause(s)
Division or Vital Records,	ling Physician: After this certifice funeral director, p	Certification: To Be	examprer? 1	28a. Date of Injur (Month, Day nee 28e. Place of injur building, etc	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deat examination and/or in	of 28c. Inju Wo M 1 = 28c. Inju Wo M 1 = 28c. Inju Wo M 1 = 28c. Inju Wo M M 1 = 28c. Inju Wo M M M M M M M M M M M M M M M M M M	ier: 4 Nursing Hom ry at 2! K? IYes 2 No 2: me, date and place, a opinion, death occurre se number	autops: perform 1 Yes 2 (Check only one e 5 Reside 3d. Describe ho 3f. Location (Str City or Town and due to the ca d at the time, di	prior to death? death? 1	ompletion of cause of 2 PNo 2 PNo ral Route Number, stated. to the cause(s) n, Day, Year)
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	Certification: To Be	examprer? 1	28a. Date of Injur (Month, Day ne 28e. Place of Injur building, etc purples of the basis of and manner sta	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deal examination and/or inted.	of 28c. Inju Wo M 1 Treet, factory, office th occurred at the transcription in my 29c. Licens	received and place, a popinion, death occurrence number	autops: perform 1 Yes 2 (Check only one e 5 Reside Bd. Describe ho Bf. Location (Str City or Town and due to the ca d at the time, do	prior to death? death? 1 Yes nce 6 Other (Spectors) nce 6 Other (Spectors) reet and Number or Ru, State) ause(s) and manner as ate and place, and due od. Date signed (Month)	ompletion of cause of 2 PNo 2 PNo ral Route Number, stated. to the cause(s) n, Day, Year) 2007
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	Certification: To Be	examprer? 1	28a. Date of Injur (Month, Day ne 28e. Place of Injur building, etc purples of the basis of and manner sta	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deal examination and/or inted.	of 28c. Inju Wo M 1 Treet, factory, office th occurred at the transcription in my 29c. Licens	received and place, a popinion, death occurrence number	autops: perform 1 Yes 2 (Check only one e 5 Reside Bd. Describe ho Bf. Location (Str City or Town and due to the ca d at the time, do	prior to death? death? 1 Yes nce 6 Other (Spectors) nce 6 Other (Spectors) reet and Number or Ru, State) ause(s) and manner as ate and place, and due od. Date signed (Month)	ompletion of cause of 2 PNo 2 PNo ral Route Number, stated. to the cause(s) n, Day, Year) 2007
Division or Vital Records,	tending Physician: leath. tor: Affer this certifice the funeral director, p	Medical Certification: To Be	examilyer? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	28a. Date of Injune 28a. Place of injune 28e. Place	y Year) 28b. Time of Injury ry - At home, farm, st. (Specify) of my knowledge, deal examination and/or inted.	reet, factory, office th occurred at the tinvestigation, in my 29c. Licens Print)	received and place, a popinion, death occurrence number	autops: perform 1 Yes 2 (Check only one e 5 Reside Bd. Describe ho Bf. Location (Str City or Town and due to the ca d at the time, do	prior to death? death? 1	ompletion of cause of 2 PNo 2 PNo ral Route Number, stated. to the cause(s) n, Day, Year) 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of N		epartment of the control of the cont		, ,	IENE eg. No.	
	Physici	an	Decedent's Name (First,					2. Date of Deat Month	Day Ye	3. Time of Death
	/Medi	cal		Leslie Woolf	r)	4b City Town	or Location of Death	July	61 200 4c. County of I	
	Examir	ner		orial Hospital	//		imore	•	,	NZA
	Funeral		5. Social Security Number	6. Sex 7. A	age (In yrs. last birth	fay) If Under 1 Year		8. Date of Birth		Birthplace (State or Foreign Country)
~	Director	ļ	217-56-8350	1 反 M 2□ F	57 Yr	s. Menute Days	Tiodio Mini.	May 11,	1950 1	Maryland
	land ow		Usual Residence of Deced 10a. State 10b. 0	County	10c. City, Town o	r Location				10d. Inside City Limits
	Mary Fe she	tor	Md. Ba	altimore	Parkt	חכ				1 □ Yes 2√ No
	or 28k	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	•
	s 23a	rall		er Hill Road		2112			144 0	USA
	ter de items Iner m	by Funeral Director	11. Marital Status 1 □ Never Married 2	12. Was Deceder Armed Forces	at Ever in U.S. 5? 1 No	 Was Decedent of I If Yes, specify Cut 	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther the Medical Examiner must be notified at	by	3 □ Widowed 4 □ Di	I If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:	White
5-0	72 ho 'natur dical	Completed	15. De (Specify only	ecedent's Education y highest grade completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of wor	king I	16b. Kind of Busin	ess/Industry
121	within sne. than t	Ig III	Elementary/Secondary (r5+) I	fe. DO NOT use retire ctrician	ed)		Constru	etion
	filed Hygid Sther ent, th	ပိ	17. Father's Name (First, A	Middle, Last)	1220	3 31 13131	18. Mother's Nam	ne (First, Middle, I		3 0 2 3 1 1
<u>lan</u>	Aental Aental rked tic ev	To Be	Lewis E. Wo	oolf			Ruth St	effe		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	177	19a. Informant's Name/Re			lailing Address (Stree				, , ,
	1 and Health em 27 ther t	1	Mrs. Linda Wo			907 Bunker			, MD . ZI 20c. Location - Cit	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra			nation 3 □Removal from Stat	e	isposition (Name of crematory or other pla Valley Mei	1		Timoniur	
altir	mit. Foortan		21. Signature of Funeral S		puraney	22. Name and Addre	ess of Facility			11,1114.
ä	permii Depar Impor any Ir			K/458		1050 Yo	wson fune rk Rd. To	ral Home wson. Md	, inc. , 21204	
Е			23a. Part1. Enter the dise shock, or heart failur	ease, or complications that cause re. List only one cause on each	ed the death. Do not line.	enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
ħ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Au	ite Mi	ocardia	1 Intar	ction		7 days
	Examiner			C n	s a consequence of)	Arteny	Diego	2		14 years
0		ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of)		Brycog	Element.		11
ph	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	yperten	sin				16 years
68760,	ificate be executed g physician and as the burial-transit	al E	in godiny Edot	Late to (or a	a e donaequence of)					
687		edical		d					- 1	
Box	Jeath certifi attending p	M/us	IF FEMALE: 23b. Was decedent pregna		ne pf pregnancy 2 Fetal death	3 ☐Ectopic pregnance	24		23d. Date o	f delivery
	The law requires that the death cert to has been signed by the attending agge 2 should be detached for use	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death	5 Other (specify)			Month	Day Year
P.0	that the dended by the a			conditions contributing to death	but not resulting in the	ne underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?
Division or Vital Records,	quires than signed	d by						1 □ Ye	es 2∐No 3[Probably 4 Unknown
CO	aw requir s been si 2 should b	Completed						24a. Was a		e autopsy findings available
Ä	(0)	mo:						autops perforr 1 Yes	ned?/ dea	r to completion of cause of th? Yes 2□ No
Vita	iclan; sertific ector,	Be	25. Was case referred to rexaminer?	medical Hospital:				th (Check only on	e)	
or	Attending Physician: or death. ector: After this certification by the funeral director,	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 1 Inpa 28a. Date of In		Ment 3 DCA			ence 6 Other (Specify)
ion	nding ith. r: Afte e fune	tion	1 Matural 5 □	Pending (Month, E	<i>Pay Year)</i> Inju	ry Wo	rk?]Yes 2 ☐ No	Edd. Describe no	w injury occurred	
Vis	r Atte	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined 28e. Place of in building,	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (St. City or Town	reet and Number o	or Rural Route Number,
	oital o urs aft eral Di									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 C (Check only 2 M one)	ertifyIng Physician: To the bes ledical Examiner: On the basis and manner:	of examination and/	or investigation, in my	ime, date and place opinion, death occu	r, and due to the car arred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the within To the	Me	29b. Signature and title of			29c. Licen			9d. Date signed (A	
			>/L-	- Slepp	MA	ATQ	438946-	-H13	July 10	1,2007
	15+1			person who completed cause of	death (Item 23a) (Ty	pe, Print) Men	ama 1 4	int l	Rult	mo
	Sta	te.	Maryle C. 31. Date filed (Month, Day,		trar's Signature	con iren	wreat te	راسانامدر	Dariel ,	
	Registr			2007	H Single	20				

death with the Maryland show Saltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Stephen B. Whitman 6/27/2007 22:52pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Baltimore MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 107571950 038-30-0052 56 RT Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. MA Middlesex Billerica Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Todd Lane 01821 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married Married 2**X2X**No 1 ☐ Yes 2CXNo Specify þ Specify. white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Manager Consulting Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bradford Whitman Helen Poland T₀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martine Whitman / WIfe 11 Todd Lane Billerica MA 01821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Linwood Crematory July 2, 2007 Haverhill, 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 2. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Victor Doda 2 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** candiovascular eniosclero disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 Ves 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an this certificate has page 2 autopsy perform 2 No 1∐ Yes Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 □ DOA Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 6 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Edwin Webster June 30. 2007 1:15 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2701 Carrollton Road Finksburg Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5, Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Yrs Director 214-30-7346 74 1933 Maryland Mar. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f show the Medical Example must be notified at 1 TYes 2 XNo Director Maryland Carroll Finksburg 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 2701 Carrollton Road 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: <u>ک</u> 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "na any injury or other traumatic event, the Meutre once. Elementary/Secondary (0-12) College (1-4or 5+) 4 Command Sergeant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edgar Webster Madeline Cooper Flaharty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Scott B. Webster / Son 1705 Stephens Pl., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 7-6-07 Towson, Maryland 21. Sign sture of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Umas 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HETASTATIC PROSTATE CANCER 14 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No o detached 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 ☐ Yes 2 No 2 this s after death.
I Director: After this id in by the funeral d 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funerel Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

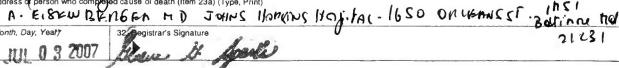
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier 29c. License number MD D533988 7/2/2007 win 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

MANIO

31. Date liled (Month, Day, Year)



21231

			1 - For State Registrar			/ Depa	artment of Hertificate of L	ealth a		ntal Hygi	_	07	21418
P ,	Physici	25	Decedent's Name (First, Middle, La	st)					2	2. Date of Death Month		Year	3. Time of Death
	/Medic	100	Matthe		Μ.		William			6 26	5 200)7	1340 M
-	Examin	er,	4a. Facility Name (If not institution, giv				4b. City, Town, or				4c. County		
	Funevel	OF A	Good Samaritar 5. Social Security Number 6. S		e (In yrs. last	birthday)		timor M Under 2		B. Date of Birth		NA 9. Birthp	lace (State or Foreign
kr.	Funeral Director			MM 2□F	75	Yrs.	Months Days	Hours	Min.	Month Day	332	Coun	N.C.
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					1	Od. Inside City Limits
	Aaryla f eho	ō	Md. NA		100.019, 1		imore					,	1 XYes 2 No
	72 hours after death with the Maryland nature!', or iteme 23a or 28a-f ehow dical Exama ar must be profitted at	Funeral Director	10e. Street and Number		1		10f. Zip Code			10	g. Citizen of	What Cour	itry?
	h with	at Di	1627 Montpelier	Street			212	18				USA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of His f Yes, specify Cubar		in? (Speci Puerto Ri	ify Yes or No-		e - Americ	
36	or It	by Fu	1 Never Married 27 Married	1 ☐ Yes 2 🔀		}	1□Yes 2X No		, , , , , , , , , , , , , , , , , , , ,	,	Specif		ack
Ö	hour:	ed b	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates:	1	6a Dece	dent's Usual Occupa	tion			6b. Kind of B		
215	9	Completed	(Specify only highest gra Elementary/Secondary (0-12)			(Give	kind of work done d DO NOT use retired)	uring most	of working	7	ob, rand of b	001110001111	
212	filed within Hygiene. Ther then out, the Mer	mo:	10th grade	College (1-401 :	0+)	Tr	uck Drive	r			Maryla	and C	up
pu	0 = 0 >	Be	17. Father's Name (First, Middle, Last,)				18. Mother	r's Name (First, Middle, N	laiden Surnar	•	
yla		^L	Coleman		Will				giele			Will	
Maryland 21215-0036	h ar h ar rieu		19a. Informant's Name/Relationship (Rothelma Willia	**			ng Address <i>(Street</i> a 7 Montpel						21218
	s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of		Da		Oc. Location		
OE I	@ ° = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil	Removal from State v)		-	natory of other place mount Ce		7-3-0	7	Balti	more,	Md.
Baltimore,	permit. Pag Department Important: I eny injury o		21. Ignatur s of Funeral Service Lices		Hard.	-	Name and Addres	s of Facility	/ Ma	arch F.			21202
			23a. art1 Enter the disease, or com shoot, or heart failure. List only	plications that caused	the death	Do not ent							Approximate Interval Between
	Pnysician /Medical Examiner	ner	Imr edia a Cause (Final di ease / r condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	babl a consequen	Ce of):	myoo	. ord	اعا	I Fr	force	19	Onset and Death
760,	e be executed rsicien and e burial-transit	ıl Examîner	Cause (Diseese or injury that initiated events resulting in death) Last	cDue to (or as	a consequen	ce of):							
687		dicai	•	d									
P.O. Box (The law requires that the death certificate te has been signed by the attending phy.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)					ite of delive onth	ery Day Year
	res that igned b	by PI	Part II. Other significant conditions			-		n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?
ıd	w require been sig should b	t pa	rulmanon	Em	- 601	; ~	~		_	1 □ Ye	s 2□No	3 ☐ Prob	ably Winknown
Vital Records,	The law rate has be page 2 ship	Completed								24a. Was ar autopsy perform 1 Yes 2	ned?	Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of
ital	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						of Death (Check only one			
	Physician: this certific ral director,	2	1 □ Yes 2 No	Hospital:		/Outpatier		4 🗀 1901		e 5 Reside			y)
on c	ing After	lon:	27, Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28	lb. Time o Injury	Work	at ? ′es 2.⊟N		d. Describe ho	w injury occur	red	
Division of	Atten er deal ector: by the	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inj	ury - At home c. (Specify)	, farm, str	eet, factory, office	95 2		Bf. Location (Str City or Town		ber or Rura	I Route Number,
_	Hospita 4 hours Funeral	Medical Ce		nysician: To the best niner: On the basis o and manner st									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	=>ph	4 1,0	ian	29c. License	number	754	10 J	od. Date signe	ad (Month,	Day, Year) LD 21239
•			30. Name and address of person who	completed cause of c	leath (Item 23	Ba) (Type,	Print)				. 4		
_	7		Teresa mur	1,00,	560)	och R	Aven	BI	ud B	allino	re, M	D 21239
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	9	1						
DH	Registr	- 4	JUL 0 3	ZUU/	was L	The fall	mer)						

ORIGINAL

		ľ	For State Registrar	State of Maryland		artment of tificate of		R	eg. No.	21419
	Physici		1. Decedent's Name (First, Middle, Last) Dolores P. W	agner				June 3	th 30 ^{0ay} 2007 ^{ear}	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Harford Memori	al Hospital		Havre	or Location of Dea De Gra	ce	4c. County of Death Harford	
	Funeral Director		5. Social Security Number 217-20-2191 6. Sex	M 2☑F		If Under 1 Year Months Days			Year) 9. Birth Cou	place (State or Foreign intry) MD
	Maryland	tor	10a. State 10b. County MD Baltimo	,	Town or Lo	cation				10d. Inside City Limits 1 ☐Yes 🎉 No
	with the	i Direc	10e. Street and Number 1000 Franklin A	ve.		10f. Zip Code 21	221	1	0g. Citizen of What Cor USA	untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Pyglene. Department of Health and Mental Pyglene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show simplying or other traumatic event, the Modical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu		Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	d within 72 ho giene. rr than "natur ine Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6th		(Give life.	dent's Usual Occu kind of work done DO NOT use retir emaker	upation e during most of w ed)	orking	16b. Kind of Business/I	(
70	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Dominick DeAng				Eve	ame (First, Middle, i		
Mar	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Ty) Jerome Wagner	oe, Print) /son					r, City or Town, State, 2 HAgerstow	
Baltimore,	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State HoT	ace of Dispo metery, crei LY H	sition (Name of majory or other pi LLI CEM	etery 7	Date /3/07	20c.Location-City or Baltimore	
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	Ouns	(y Funer	al Home	Ave. Bal of Essex	
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused Me death e cause of each line. Due to (or as a consequ	Do not end	er the mode of dy	ring, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset Ind. at
760, <	be executed iicien and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	carde odery	al is	ma forct ase	ion'	Ine Wech Years
.O. Box 68	death certifica e attending ph od for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnan Other (specify)	су		23d. Date of del Month	very Day Year
<u>α</u>	quires that n signed b uld be deta		Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying cause o	given in Part I.	23e. Did to	bacco use contribute to es 2 No 3 □ Pr	the cause of death?
l Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	Hypertensio	~	-			24a. Was a autop perfor	sy prior to o	topsy findings available completion of cause of
Vital	Physicien: this certific ral director,	To Be (25. Was case referred to medical examiner?	ospital: In atient 2 -	ER/Outpatie	nt 3□ DOA C	thor	eath (Check only or	ne) ence 6 ⊟Other (Spe	cifv)
ion of	ling After une	ation: T	27. Manner of _eath 1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	f 28c. In			ow injury occurred	
Division	교육등	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, st)	reet, factory, offic	е	28f. Location (S City or Tow	treet and Number or Ru ก, State)	iral Route Number,
	the Hospital nin 24 hours the Funeral npletely filled	Medical	(Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examinat and manner stated.		ivestigation, in my	opinion, death oc	curred at the time, o	date and place, and due	to the cause(s)
	with: To t	×	29b. Signature and title of certifier	Bruch, n	NA		1369	40 =	SUNE 30	1, Day, Year)
_	6		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type	Print) HAR TH UNITE	FORD MI ON AVEX	NE HA	LHOSPITAL	DALE 210%
5	Sta Regist		31. Date filed (Month, Day, Year)**	92. Sgistrar's Signat	ure	nack			7	

DHMH 17 Rev 1/2001

DOLDRES

COSOAM WAGNER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death Day 2007 **Physician** July 1 12:15 P M Marilyn Jane Walker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11602 Parkedge Drive Rockville Montgomery 8. Date of Birth (Month, Day, Year) April 11, 1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🖺 F Hours Min. Ohio 070-20-4159 80 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at gones. 1 ☐ Yes 2 No Director Oberlin Ohio Lorain 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44074 43 Kendal Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Special Education Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gabriel Pereira Gertrude Kahlmeyer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Q. Walker/Husband 43 Kendal Drive, Oberlin, Ohio 44074 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery 20a. Method of Disposition 20c. Location - City or Town, State July 3, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 2007 Crematorium, Robert A. Pumphrey Funeral Home/Sethes la-Chevy Chase. Inc. 21. Signature of Funeral Service Licensee Chase, In 20814-3501 Inc. M00198 7557 Wisconsin Ave., Bethesda, MD23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Pancreatic Cancer Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-tran or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 N No 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Home 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the nospinal within 24 hours after death.

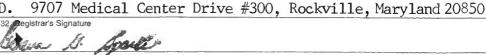
To the Funeral Director: Af the Hospital

Registrar

29b. Signature and title of certifier

John M. Wallmark, M.D. 31. Date filed (Month, Day, Year) 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

29c. License number

D53177

29d. Date signed (Month, Day, Year)

July 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 1, **Physician** 2007 Christina Zimbalardi Diomira 12:00 PM /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner 117 St. Andrew Court Aberdeen Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 25, 1930 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □ XF 77 201-22-2770 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XNo Director Harford MD Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 St. Andrew Court 21001 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carlo Nardizzi ပို Chiara DeMario 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Kronn, Daughter 117 St. Andrew Court, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of Inportant: If Ite 1 Burial 2 Cremation 3 X Removal from State Sts. Peter&Paul Cemetery July 6,2007 Springfield, Pernsylvania 4 □ Donation 5 □ Other (Spacify) 22. Name and Address of Facility 21. Signature of Funer Harman Funeral Service, P.A. M01113 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed tours after death.

meral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be deteched for use as the burial-transit P.O. Box 68760.69 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Z No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32279 5-143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MAC Dov. D

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

			Plea	se Type or I					•		egible.	
			For State	State of	Maryla			Health and	Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle	a /act)			ertificate c	or Death	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an							Month	Day	Year	
	/Medic		Linda L. 4a. Facility Name (If not institution	Alford-Mod			4b. City, Town	n, or Location of Deat	June h	14 4c. C	2007 ounty of Death	8:18A M
7	Examin	iei	Anne Arund			er		Annapolis				Arundel
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr		(ay) If Under 1 Ye Months Da	ar If Under 24 Hrs	8. Date of Bir	th v Year)	9. Birth	nplace (State or Foreign
	Director		579-84-4549	1 □ M 2 🂢 F	5	0 Yrs	.	, Tiodio iviiii.	Jan. 1			ash., DC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or	Location					10d. Inside City Limits
	Maryl f sho	ō.		G 1			T	•				1 XYes 2 No
:	r 28a	Director	Maryland Princ 10e. Street and Number	e George's	5		10f. Zip Cod	owie e		10g. Citize	en of What Cou	ıntry?
	th with	al D	10601 Heyb	oury Ct.				20721			United	d States
Ì	ems ems	Funeral	11. Marital Status	12. Was Dece Armed For	rces?	U.S. 1	3. Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.))- 14	Race - Amer Black, White	
2	or It	by Ft	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes If Yes, Giv	2 No		1 □ Yes 2/∇ I		,			lack
3	hour tural	ed b		Year or Da	ites.	16a. De	cedent's Usual Oc	cupation		16b. Kind	I of Business/I	
2	nin 72 .n "na Medic	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(G lif	ive kind of work do e. DO NOT use re	ne during most of wo tired)	rking	97		,
7	d with giene er tha	Completed	Elementary/decondary (5 12)	9	401 37)		School	Psycholog	gist	S	elf-Em	ployed
2 :	be file tal Hy d oth event	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle			
<u>X</u>	nould I Men narke natic	ဥ		ng Alford		401. 14	-10 A.I.I (O4-	-111-111		a Bro		
2 2	d 2 sh th and 7 is n traun		19a. Informant's Name/Relations Kevin P. Mod			19b. M		eet a <i>nd Number</i> or <i>R</i> Heybury C				
ָט .	Heal Heal tem 2		20a. Method of Disposition	ore, opease	20b	. Place of Di	sposition (Name of		Date		ation - City or	
<u> </u>	Pages entoi nt: If I		1√ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		crematory or other	etery 6/2	0/2007	P.	rentwo	od. MD
= = = = = = = = = = = = = = = = = = =	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		1		22. Name and Ad		Stewart			
٥	8 3 2 5 5		Tolunt	. Sleves	X III		4001	Benning	Rd., NE	Wash	., DC	20019
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can only one cause on e	aused the de ach line.			dying, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Caùse (Final disease or condition resulting in death)	d.	Rim		17.055					18 mos
ı	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or as a cons	equence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a cons	equence of):						
	oe executed cian and curial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С								
Š,	e exe vian ar urial-t		resulting in death) Last	Due to (or as a cons	equence of):						
0/00	cate b	dica		d								**
5 X	certifi ding p	/Me	IF FEMALE:	23c. If yes, out	come of pred	nancv				20	ld Date of deli	liven.
	ding Physician: The law requires that the death certificate by not after this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐Live b	irth 2 □ Fo	etal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23	d. Date of deli Month	Day Year
<u>;</u>	t the c by the ached	hysi	9 Unknown	9□Unkno								
, ,	s that gned t	by P	Part II. Other significant conditi	ons contributing to de	ath but not r	esulting in th	e underlying cause	given in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
cords,	equire en sig ould b								1 🗆	Yes 2	(No 3□ Pr	obably 4 □Unknown
ני ע	law r as be	Completed							24a. Was			topsy findings available completion of cause of
=	: The cate by page	Son							perf 1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2□ No
	iclan certifi ector	Be	25. Was case referred to medica examiner?	Hospital:	_			Other:	ath (Check only			
5 i	Phys r this ral di	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		☐ ER/Outpa 28b. Tim	tient 3 DOA	4□ Nursing	Home 5 ☐ Res 28d. Describe			city)
5	ndIng th. :: Afte e fune	tion	12 Natural 5 ☐ Pendir 2 ☐ Accident investi	19	h, Day Year,	Inju	ry	Work? 1 ∐ Yes 2 ∐ No		,		
2	· Atter	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Place	of injury - At	home, farm,	street, factory, off	ice	28f. Location	(Street and wn, State)	Number or Ru	ıral Route Number,
5	pital ol urs afte eral Di											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendenth. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only 2 Medical one)	ng Physician: To the Examiner: On the band man	asis of exam ner stated.	ination and/o	or investigation, in I	ny opinion, death occ	curred at the time	, date and p	and manner as place, and due	e to the cause(s)
i	To t withi To tl	ž	29b. Signature and title of certifie	m/m				ense number		29d. Date	signed (Monti	h, Day, Year)
)	10		/toby 1	Woten				8118		JUN	1214	2007
	3		30. Name and address of person	WATK	125	90	pe, Print) Bris	STUATE	no B	NNA	rous	2007
H	Sta	ite	31 Date filed (Mo2007 Year)	32.5	gistrar's si	pare						

			For State Registrar		State	of Maryla				ealth a Death	nd M	ental Hy	ygiene Reg. No.	200	1-1		:23
	Physici	an		ime (First, Middle								2. Date of D June	eath Day 15		ear (3. Time of	
	/Medic		Betty	Armstro								June				2:37	A M
	Examin	er			, give street and n	umber)				Location of				County of			
			5. Social Security	ross Hos	6. Sex	7. Age (In yrs	. last birthday)			pring		8. Date of 8	irth		9. Birthp	lace (State o	r Foreign
	Funeral Director		578-50-		1 □ M 2 🔀 F	72	Yrs.	Months	Days	Hours	Min.	May 9	ay, Year)		NC.	try)	J
-	D.		Usual Residence	of Decedent									, 1,5				
	arylar ehow	-	10a. State	10b. County			ity, Town or Lo								1	0d. Inside Ci 1 1 Yes	
	8a-f	ecto	DC			was	shingto	10f. Zir	Code	_			10= Citi	zen of Wh	at Cour		
	with t	声	10e. Street and f	vumber th Stree	t. NE				0002				USA		iat Cour	uyr	
	tiled within 72 hours after deeth with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-f ehow that the Madical Examenation met be notified a	Funeral Director	11. Marital Status		12. Was De	cedent Ever in l	J.S. 13. V	Was Dece	dent of Hi	spanic Orig	in? (Spe	cify Yes or N		14. Race			
9	or Iter			arried 2□ Marı	Armed F	2 No		f Yes, spe 1 □ Yes		n, Mexican,	, Puerto I	Rican, etc.)			White,		
5	irel', c	d by	3 🗆 Widowed	4 Divorced	If Yes, G Year or	Dates:		TU Tes	21 A NO	Specify:				Specify:	В	lack	
21215-0036	netu dica	Completed	(Sp	15. Deceden becify only higher	t's Education st grade completed	")	16a. Deced	dent's Usu kind of wo	al Occupa	ation furing most)	of workir	ng	16b. Ki	nd of Busi	ness/Ind	dustry	
7	withir ene. then	dmo	Elementary/Se	econdary (0-12)	College 1 yr	(1-4or 5+)	Milita						Dep	t of	Def	ense	
7 0	filed Hygi other	Be Co	17. Father's Nam	ne (First, Middle,								(First, Middl	1				
<u>la</u>	should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. s marked other then "neturel", or Items 23a or 28a-1 show umatic event, the Madical Examinar must be notified at	To B	Connie	Wilkins	s, Sr.					Mary	Jor	ies					
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic es <u>onca.</u>				hip (Type, Print)							l Route Num			tate, Zip	Code)	
≥ o`	and leaith im 27				ngfellow/		r 1009 Place of Dispo			IE Was		ston,		0002 cation - C	iby or To	un Ctata	
و	ages or of h			2 Cremation	3 Removal from	n State	cemetery, crer	natory or o	other plac								
Baltimore,	artmer artmer ortant injury	- 1		n 5 ☐ Other (S Funeral Service		L1	ncoln M	Name a	Lat C			-2007 shall'					2.
ä	tape on y		7	0 .	n ha	. 1 . 00						shing			2001		
	Physician /Medical Examiner		Immediate Caus disease or cond resulting in deat Sequentially list	se (Final lition h) conditions.	Due to	trointe o (or as a conse	stinal quence of):			g, such as o	cardiac o	r respirato <i>r</i> y	arrest,		i	Approximat Interval Bet Onset and I	ween Death
68760,	death certificate be executed e attending physicien and d for use as the burial-transit	edical Examiner	if any, leading to cause. Enter Ur Cause (Disease that initiated eve resulting in deat	nderlying or injury ents	G	o (or as a conse											ł
P.O. Box	at the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was deced in the past 1 Yes 9 Unknown	12 months? 2 XNo	1 Live	utcome of pregr birth 2 Pet gnant at time of nown	aldeath 3□	Ectopic p Other (s					1	23d. Date Mont		-	Year
	law requires that the as been signed by the 2 should be detache	þ		nificant condition	ons contributing to	death but not re	sulting in the u	nderlying	cause give	en in Part I.						ne cause of c	
Records,	w requ	Completed	-									24a, Wa	is an	24b. W	ere auto	psy findings	available
Ä	sicien: The law certificete has l irector, page 2 s	ошо		ension	· · · · · ·							aut per	opsy formed?	pri de	or to col	mpletion of a	ause of
<u>e</u>	en:] tificel tor. p	Be C	25. Was case re	es mel1:						26. Place	of Death	(Check only			1 102	245 140	
ot Vital	ıysıcı iis cər dirəc	To B	examiner?	™ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 Do	Othe	200		ne 5□Re		6 🗌 Other	(Specif	v)	
o L O	Attending Physicien: Ir death. ector: After this certific by the funeral director.		27. Manner of De 1 ▼Natural 2 ☐ Acciden	5 Pendir	9	e of Injury inth, Day Year)	28b. Time of Injury	м	28c. Injury Work	rat ⟨? Yes 2 □ N		28d. Describe	how injur	y occurre	d		
Division	5 to to to	Certification:	3 ☐ Suicide 4 ☐ Homicid	6 □ Could de determ	inod 288. Plac	ce of Injury · At I ding, etc. (Spec	home, farm, str hify)	eet, factor	y, office		2	281. Location City or T	(Street an own, State		or Rura	i Route Nurr	iber,
	To the Hospital or Within 24 hours efter To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	1 X Certifyir 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kn basis of examin inner stated.	owledge, deatl	n occurred vestigation	at the time, in my of	ne, date and pinion, deat	d place, a	and due to the	e cause(s) e, date and	and man	ner as s id due to	tated. the cause(s	6)
	To the To the complet	ž	29b. Signature	nd title of certifie	r			29	c. License	number				-		Day, Year)	
	(1,)			82	MD			D	2865	6			June	15,	2007	7	
(Cox P				who completed ca						M	20010					
	ع الحرو				500 Fores	t Glen Registrar's joi		11 v e	r Spi	ring,	MD	20910					
	Sta Registr		31. Date filed (N	5 2007	Beneve 32.	1. 19											

Examiner burial-1 Box 68760. physician death certificate be the l ası nse P.O. the signed by t I be detach Division or Vital Records, peen hash page certificate director, After this funeral To the Hospital or Attendii
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu

28a-f show

death

within 72 hours after

than

marked other

es 1 and 2 should be fil of Health and Mental H f Item 27 is marked ott

Pages 1

Maryland 21215-0036

Saltimore.

5 State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of sertifier



Raman Tuli, M.D. 3503 Perry St., # B, Mt. Rainier, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29d. Date signed (Month, Day, Year) June 20,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** an Docson 021 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 📉 68 029-30-0644 Aug 8, 1938 Director Conn. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at MDCalvert 1 ☐ Yes 2X No Huntingtown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2321 Huntingfields Drive 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the fold Health and Mental Hygiene. The filem 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) <u>Administrative Assistant</u> Federal Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar В. Hume Lois 2 Warren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Robert Anderson (husband) 2321 Huntingfields Drive Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State i if it Jun [□]21 Department o Important: If any Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory 2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, 21. Signature of Inneral Service Licenses dary J. 8125 Southern Maryland Blvd. 20736 Owings, MDApproximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physiciar Physician/Medical use as the led by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> page 2 should be 2 No 3 Probably 4**℃**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA 1 Nnpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After 1 Natural 5 ☐ Pending investigation Injury 2 No 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner state within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1

32. Registra s Signature

			For State Registrar	State of Marylar		artment of rtificate of		and Mental	Hygien Reg. N		21425
	Physici	an	1. Decedent's Name (First, Middle, Last	_	271 '			2. Date of Month	of Death	^{ay} 2007 ^{Year}	3. Time of Death a 8•45 M
	/Medic	al	Sheryl 4a. Facility Name (If not institution, give		Adkin	5 4b. City, Town	or Location o			c. County of Death	0.45
	Examin	er	1504 Mt. Hermon				sbury			Wicomic	
	Funeral Director		216-74-3600	x	last birthday) Yrs.	If Under 1 Year Months Day		Min. (Monti	of Birth n, <i>Day</i> , Yea 2/196]	Col	uplace (State or Foreign untry) uryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	Mary	tor	Maryland Wicomic	o S	alisbu	ry					1 ☐ Yes 2 ☐ No
	or 28 c	Directo	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	a 23a	erail	1504 Mt. Hermon	12. Was Decedent Ever in U	15 13	218		gin? (Specify Yes	or No-	USA 14. Race - Amer	ican Indian
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or itama 23s or 28s-f show stry injury or other treumatic event, the Medical Exeminant he notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Namried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Co	uban, Mexican	, Puerto Rican, etc	.)	Black, White	
- - 2	72 hou	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occ kind of work dor	ne during most	t of working	16b.	Kind of Business/I	ndustry
12	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)	J		-1-1- D	-7. CI
0 0	filed v Hygie Sthar t		12 17. Father's Name (First, Middle, Last)		Own	er	18. Mothe	or's Name (First, M		ealth Foo on Sumame)	d Store
lan	ould be Mental Mrkad o	To Be	Graham M. Hotton	Sr.							
Maryland 21215-0036	2 should and Men is marka reumatic		19a. Informant's Name/Relationship (T			3		or or Rural Route N			
	1 and Heelth em 27 thar t		Homer Adkins/husb	20b.	Place of Dispo	sition (Name of		d., Salis		Location - City or	
timore,	Pages nent of int: if it		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		matory or other p y Cremat		6/20/07	Sa	lisbury,	MD
Balti	permit. Page Depertment of Important: if eny injury or once.		21. Signature of Funeral Service Licens	500		2. Name and Ado Holloway	<i>i</i> Funer	al Home I	Profes	ssional A	association 304
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications hat caused the dea	_					7 110 210	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	a. Cancir	on a	05	br	15,57			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						
		Jer	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of):						
	ocuted nd transit	Examiner	that initiated events	c							
8760,	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):						
687	ficate physics the	edical		d.							
Box	The law requires thet the death certifics ate has been signed by the ettending plagge? should be detached for use as I	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1 □ Yes 2 ☒No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	⊒Ectopic pregna ⊒ Other (s <i>pecify</i>)				23d. Date of deli Month	very Day Year
<u>о</u> .	et the d by th etache	Phys	9 Unknown	9□ Unknown			Maria Barat	220	Did tabasa		the cause of death?
ords,	w requires th been signed should be d		Part tt. Other significant conditions co	ntributing to death but not re	suiting in the t	inderlying cause	given in Part I.	ì	1 🗌 Yes		obably 4 灯 Unknown
Division of Vital Records,	The law rate has be	Completed							Was an autopsy performed?	death?	topsy findings available completion of cause of
Vita	ician: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check			
0	Attending Physician: r death. ector: After this certifica by the funeral director.	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Yeer)	28b. Time o		ijury at Vork?	rsing Home 5 28d. Desc		6 □Other (Specured	city)
ion	ath. r: Afte	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		tnjury		Vork? ☐ Yes 2 ☐	No			
Divis	si or Atte s efter de si Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, factory, offic	ce ce	28f. Local City of	tion (Street or Town, Sta	and Number or Ru ite)	ral Route Number,
	o the Hospital or Attending Physician: The lavillin 24 hours effer death. o the Funerel Director: After this certificate has empleately filled in by the funeral director, page 2	edical (psician: To the best of my kin liner: On the basis of examin and manner stated.							
	To the To the Complet	ž	29b. Signature and title of certifier	101			ense number			Date signed (Monti	•
C	Q.V		I plan "	CS IN			2541	0	1	1/3/0)
1	14		30. Name and address of person who of Dr. Floyd Gray	completed cause of death (the 223 Phill			Salie	bury, MD	21804	L	
4	Sta	ate	31. Date filed (Month, Day, Year)	32. A gistrar's Sign			DULLD	~GLY/ PID	21009	•	
1 3	Regist		JUN 15 2	2007 Sour	D. 19	berte					

		For State Registrar	State of Maryland	d / Department of Health and Certificate of Death	Mental Hygiene	2007 21427
Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Lasi MARGUERITE 4a. Facility Name (If not institution, give	BRAATEN	4b. City, Town, or Location of Dea	2. Date of Death Month Day	Year J:45 PM County of Death
Funeral Director) P	SENESIS 24° 5. Social Security Number 6. Se	TRUCKHOUSE A	SEVERNA PARK sst birthday) If Under 1 Year If Under 24 Hr. Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign WARWAND
U	ector	Usual Residence of Decedent 10a. State 10b. County AWNEAR	undel Pa	Town or Location		10d. Inside City Limits 1 Yes 2 No
21215-0036 within 72 hours after death with the Maryland isne. rthen 'natural', or Iteme 23a or 28a-f show the Madfeel Examiner must be notitled at	d by Funeral Director	10e. Street and Number 1859 Marsian Hos 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	10f. Zip Code ZIIZZ S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 22 No Specify:	Specify Yes or No-	14. Race - American Indian, Black, White, etc, Specify: White
21215- 3d within 72 giene. er then 'na	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) LOW OFFICER 18. Mother's Na		NK (NG Sumame)
Marylan d 2 should be th and Mental if I e marked of traumatic ave	To Be	JAMES BERGE 19a. Informant's Name/Relationshi. (7	SAAND	19b. Mailin Address (Street and Number or F	CLEMEN	73
timo trent of rant: If injury or		20a. Method of Disposition 1	Removal from State	ace of Disposition (Name of Immetery, crematory or other place) ENT CLEMATORY 22. Name and Address of Facility	26-07 Han	
Physician /Medical		23a Paul. Enter the disease, gromp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	offications that weed the death one across on each line. a. RUPTURE? Due to (or as a consequ	. Do not enter the mode of dying, such as cardion ABDOMINAL AOA	nd - Pasadena, MD. 2 ac or respiratory arrest,	Approximate Interval Between
8760, State be executed by sicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ence of):		
BOX 68 death certifica e attending ph	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
<u> </u>	by	Part II. Other significant conditions of	ontributing to death but not resu	liting in the underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
Vital Records, sicien: The law requires to certificate has been signe lirector, page 2 should be a	Be Completed	25. Was case referred to medical examiner?		26. Place of D	24a. Was an autopsy performed? 1 Yes 2 No eath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vita let or Attending Physician: s after death. I Director: After this certification by the funeral director.	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	EP/Outpatient 3 DOA Other: 4 Nursing 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No me, farm, street, factory, office	Home 5 Residence 28d. Describe how inju 28f. Location (Street ar	
Div To the Hospitel or A within 24 hours after Vothe Funeral Direc completely filled in b	cal	(Check out) 1 Madical Evan	ysician: To the best of my know	wiedge, death occurred at the time, date and pla	City or Town, State) and manner as stated.
To the within To the comple	Me	29b. Signature artificite of certifies	Vallan	29c. License number D3/136	29d. Da	te signed (Month, Day, Year) [NE 27, 2007
St. Regist	ate rar	31. Date filed (Month, Day, Year)	NALLACE WAS Registrat's Signal	29c. License number D31136 23a) (Type, Print) W 9005 KILBALI ture	IE RO, BA	4 more 1 MD 2123

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 2007 8:00 A ANN BROWER JUNE 15 DORETHIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER_SPRING If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 ☐ M 2 🖫 F 49 579-76-8153 1958 WASHINGTON, DC Director Jan 27 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be maritimal as 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Y∏Yes 2 No PRINCE GEOEGE'S SUITLAND MD Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 U.S.A. 4164 SUITLAND ROAD # 302 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRONA BRADY ALVIN BROWER JR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6501 LANDOVER ROAD CHEVERLY, MARYLAND 20785 ASHIYA M. BROWN/DAUGHTER Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/21/2007 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 21. Si water of Funeral Service Lic 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTASIS BREAST CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by sign be 2 No 3 Probably 4 ∭Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? /es 2 No 1∐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 □ DOA Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Vital Records, Division To the Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the i BA

> State Registrar DHMH 17 Rev 1/2001

illed (Month Day 1 9 2007

KANWALJIT K.

29b. Signature and title of certifier

29a. Certifier (Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NAGI M. D. 1500 FOREST GLEN ROAD SILVER SPRING, MD

1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

20056063

29d. Date signed (Month, Day, Year)

20910

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 21, Day 2007 **Physician** Richard Harry BRANT 115 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months 1XM 2□F Director 216-30-1983 74 Nov. 11, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or itame 23s or 28s-f ehow The Medical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18018 Pin Oak Drive 21740 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1954-56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) auto mechanic 12 0 fuel supply permit. Pages 1 end 2 should be fils.
Department of Heelth and Mental Hy
Importent: If Item 27 is marked oth
eny injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Eugene Brant Pearl D. Willison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl E. Brant - wife 18018 Pin Oak Dr., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 6/23/07 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Near Failure whre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ig physicien and es the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical ettending phy IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ page 2 should be Discase 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed3 certificete 20 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After Natural 5 Pendina investigation M 1 ☐ Yes 2 ☐ No 24 hours efter death. 2 Accident in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Mile of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00062327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 MILL ST. HAUSANTOW N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 2 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

Registra/s Signature

JUN 1 9 2007

-			_	^	^	
1/	'-C	14	Э	ö	О	

3	11	1.1	8.0		1	1	0
1	U	J	I	.)	4	2)

7-04586	n Br	Please Ty	pe or Print in tate of Maryla	Black Ind nd / Denat	delible Ir tment of	nk. Ensi Health a	ure Al and Ma	ı Copi ental F	es Are Leg Ivaiene	bie.			
Indrew Augustine		For State	tate of Maryla	Cerl	tificate of	f Death	aa	0111011		. No.			
	R	egistrar . Decedent's Name (First, Midd	dle Last)						2. Date of Death		3. Time of Death		
Physician M Examin				orm Tr					Month June 16, 20	Day Year 007	0110 hrs		
LXaiiiii		a. Facility Name (if not instituti	gustine Br	mber)	. 	4b. City, Town	, or Locat	ion of Dea	th	4c. County of D	eath		
		Prince Georges Hosp		,		Cheverly	,			Prince Geo	·		
	٠,	5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under 1	Year If l	Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9	. Birthplace (State or		
Funeral Director	- 1			39	Yrs		Days H	lours M	in. 09/08		oreign Cowntysh., DC		
Director	L	579-04-7121	1 X M 2 F	39	113	·]	L		03700	7 2 3 0 .	77		
~		Jsual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loca	tion					10d. Inside City Limits		
w any	- [DC	,			Ţ	Jachi	ngtor	1		1 XYes 2 No		
land f shc	ġ.					10f. Zip Co		11800	10	g. Citizen of What	Country?		
death with the Maryland or items 23a or 28a-f show nust be notified at once.	Director	10e. Street and Number						_					
h the	- 1			#1	5 Japan	as Decedent 6	2001	Origin2 (Specify Yes or No-	ed States American Indian, Black,			
h with	Funeral	11. Marital Status Never Married 2	Armod E		S. 13. W	Yes, specify C	uban, Me	xican, Pue	rto Rican, etc.)	White, e			
deatl	<u> </u> 를		1 Yes	2 X No		V 2	No co	ocifu:	Specify: Black				
after	by		Divorced If Yes, Give Year or Dates			Yes 2 X			Эрсопу.				
hours afte "natural", Examiner	Pa l	15. Decedent's Education (Sp			during r	most of workin	g life. DO	NOT use	retired)	24.0			
an " real F	je	Elementary/Secondary (0-1)	z) College (1-4 01 5+)	ļ		a 1			C.	277 2 Marian Can #		
otthir	Completed	12th	1 1 - 2 1				Cook 18.M	tother's Na	me (First, Middle, Maiden Surname)				
5-C iled v Hygind oth		17. Father's Name (First, Midd							Barbara Tucker				
121 121 d be f ental arke	Be	Andrev 19a. Informant's Name/Relation	A. Brown,	Sr.	19b. Maili	na Address (Street and	d Number	or Rural Route Nun	ber, City or Town,	State, Zip Code)		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other translatic event, the Medical Examiner must be notified at once.	٩					205 D_			#1. Wash.				
MI d 2 s alth a m 27		Barbara B1 20a. Method of Disposition	rown/Mother	20b.		osition (Name			Date 20c. Location - City or Town, State				
rre, s 1 au of He If ite		1 X Burial 2 Cremat	tion 3 Removal f		crematory or	other place)							
Page Page ant:		4 Donation 5 Other	Specify:	Ha	rmony	Memori	al Pa		6/23/07		over, MD		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than injury or other transmatic event, the Medical injury or other transmatic event, the Medical		21. Signature of Funeral Servi	ice Licensee							Funeral			
a a a a a a		John I.	I livered LC			400	1 Ber	ning	Rd. NE	Wash	DC 20019 Approximate Intervi		
ıysician		23a. Part Enter the disease, failure. List only one cau	or complications that	caused the death	n. Do not ente	r the mode of t	ayıng, suc	ii as cardi	ac of respiratory an	Cot, one on a meet	Between Onset and Death		
/Medical		Immediate Cause (Final disea	Cumahat V	Vound of To	rso								
Examiner		or condition resulting in death		a consequence	of):								
		Sequentially list conditions,	b		onsequence of):								
	iner	if any, leading to immediate cause. Enter Underlying Cau		a consequence									
	Examine	(Disease or injury that initiate events resulting in death) La	Due to /or as	a consequence									
cecuted 1 and 1 transit	Ĕ	events resulting in accus,	d.										
6 = =	ical	UNPENDED	AMENDED)									
Sox 68760, leath certificate be exe e attending physician a for use as the buriat -	sician/Medi	IF FEMALE:	23c. If yes	, outcome of pre	gnancy					23d. Date of			
876 ifficat ng ph	2	23b. Was decedent pregnant past 12 months?	to the a	birth	2	Fetal death	3	Ectopic pr	egnancy	Month	Day Year		
X 6 h cer tendi	icia		7	gnant at time of o	death 5	Other (Specif	fy)						
Bo e deat the at	Phys			nown	-	1 1 1 2 2 2		n in Dort I	23e Did	tobacco use contri	oute to the cause of death?		
s, P.O. litres that the signed by t		Part II. Other significant co	nditions contributing	to death but not	resulting in th	ne underlying o	ause give	en in Part i			Probably 4 Unknown		
res th	d by								-		Vere autopsy findings availal		
ords, v requir s been s	Completed	1								ppsy P	rior to completion of cause of		
COI law has l	ᇛ								per 1 ✓ Yes		eath? ✓ Yes 2 No		
Of Vital Recoling Physician: The law After this certificate has uneral director, page 2 sl	3					2	6.Place of	f Death (Cl	neck only one)				
tal clan; ector	8	25. Was case referred to me examiner?	Hospital:	Inpatient 2	✓ ER/Outpat		01		lursing Home 5	Residence 6	Other:		
Nysia Tribis	ြု	1 ✓ Yes 2 No]	28b. Time		8c. Injury		28d. Describ	e how injury occurr	ed		
1 of Ving Phy	ڃَ	27. Marrier of Bodin	_ Jun 1	ite of Injury oth Day Year) 5, 2007	2349 hrs			s 2 🗸 N	。 Subject sh	ot			
ion trend teath.	j	3	rending			to at factors	-		i	(Street and Numb	er or Rural Route Number, C		
Division pital or Attent ours after death teral Directors filled in by the	Certification:	3 Suicide 6	Could not be	ace of Injury - Al	_	street, factory,	office buil	iaing, etc.	or Town				
Dital ours a seral I	1	4 Momicide		fy) Emerger									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burit	=	29a. Certifier 1 Certifyin	ng Physician: To the b Examiner:On the bas	est of my knowl	edge, death o	courred at the	time, date	e and place	e, and due to the ca rred at the time. da	use(s) and manner te and place, and c	as stated. Jue to the cause(s)		
To the Hos within 24 h To the Fin	Medical	one) 2 Medical	and manne	is of examination or stated	n and/or inves						ed (Month, Day, Year)		
F3F8	\$	29b Signature and title of co	ertifier			29c	. License						
(2)		1 1 16.	Parlos XI	\triangle			O.C.M	l.E.		June 16, 2			
		30. No am dress of pe	erson who completed c	ause of death (It	em 23a)								
مي تو	Î.	Laron Locke MD.	Assistant Medi			enn Street,	Baltim	ore, MD	21201				
	 Stat		(ear) / 32.	. Registrar's Sigr	ture								
Regi		11111 97 65 21161	Baran	1. 19	our -								
DHMH 17 Rev 1		OCMÉ	100000000000000000000000000000000000000		ORIGI	INAL							
D111601 1 1 1/0 4 1													

		•	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H		•	giene Reg. No	007	21432
	- F2714	#Ç	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	Physici /Medio		Lester Curtis	Brooks				June	16	2007	22:30 PM
	Examir	7	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. (County of Death	
		nylla Ny	Calvert Manor Hea			Rising				Ceci1	
- E	Funeral Director		5. Social Security Number 6. Security Number 239–18–8129	M 2DE	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ıy, Year)	Col	nplace (State or Foreign untry) h Carolina
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				20 00000	10d. tnside City Limits
	•how	2									1 Yes 2 No
	28e-f	Director	Maryland Cecil 10e. Street and Number	1	North Ea	St 10f. Zip Code			10a Citiz	en of What Co	
	with	급	137 Kirks Mill Lan	3.0		,		ĺ			,
	eath	era		12. Was Decedent E	ver in U.S. 13	21901 Was Decedent of H	ispanic Origin? (Specify Yes or No		ed Stat	
10	r Ken	Funerai	1 ☐ Never Married 2 Married	Amed Forces? 1 XYes 2 ☐ N	0	If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)		Black, White	
936	of', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	J.S. Army	1 ☐ Yes 2 💢 No	Specify:			Specify: Wh	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. do other then "naturel", or items 23s or 28e-f ehow event, the Medical Exatining chall be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation	orkin a	16b. Kin	d of Business/I	ndustry
21	within 7 ene. then "r	pie	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired	during most or we	,, x, i g			
21	ygien Frth	Con	7		Ento	nologist				ernment	
nd	12 should be filed within h and Mental Hygiene. 7 is marked other then "treumatic event, the Mes	Be	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden S	Sumame)	
yla	Men Men Marke Marke	ို	Tyra Brooks				Ida Bı				
Nar	2 sh and 1s m		19a. Informant's Name/Relationship (Ty	pe, Print)		ng Address (Street					
	teath teath		Carol Patchin / Da 20a. Method of Disposition	ughter	20b. Place of Dispo	Kirks Mil	1 Lane,	North Es	st,	Marylan	d 21901
Baltimore,	permit. Pages 1 ar Department of Hea Importent: if Item : eny injury or other ance.		1XXBurial 2 ☐ Cremation 3 ☐ P	emoval from State	cemetery, crei	matory or other place	1 1 1 1 1	ne	200. L00	ation - City of	TOWN, State
ŧ	t. Pa		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur		New Bridg						Maryland
Bal	Depa Impo eny ir		21. Signatur 31 meru service us inse			2. Name and Addres		rouch Fu			
115	40200		23a. Part1. Enter the disease, or compli	antia that assumed						ast, Ma	ryland 21901
			shock, or heart failure. List only or	e cause on each lin	9.	er the mode of dyin	ly, such as cardie	ic or respiratory a	11651,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		monia						Zurells
10	/Medical Examiner		1	Due to (or as a	consequence of);						51-
		<u>-</u>	Sequentially list conditions,		consequence of):						15 years
	nsit	min	Sequentially list conditions, if any, loading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events								
,	n and	Examiner	resulting in death) Last		consequence of):						
8760,	ate be executed thy sician and the burial-transit	dical		J							
9	tificat ig phy as th	ledi							11		
Вох	eath certific attending p	an/N	23b. Was decedent pregnant	3c. If yes, outcome of		Ectopic pregnancy	,		2	3d. Date of deli	
	the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t		Other (specify)				Month	Day Year
P.0	that the ded by the	Phy	9 Unknown								
	8 6 9	by	Part II. Other significant conditions cor	itributing to death bu	t not resulting in the u	nderlying cause giv	en in Parti.				the cause of death?
Records,	w requir been si should	Completed							Yes 2	1NO 3[]FI	obably 4 Dunknown
ec	has b	npie						24a. Was	psy	prior to c	topsy findings available completion of cause of
E F		Ö						1 Yes	2 No	death? 1 ☐ Yes	2 No
Vital	ysician: Tis certifical	Be	25. Was case referred to medical examiner?	lospital:		! Oth		eath Check only			
of	hys this al di	P.	1 Yes 2 No	1 Inpatier			4 🗀 IYUISIIIG	Home 5 Res			cify)
		ion	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	k? Yes 2 □No	28d. Describe	now injury	occurred	
Division	Attendideath. ctor: A y the fu	lical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Inju	ry - At home, farm, str		103 2 []110	28f. Location /	Street and	Number or Ru	rai Route Number,
Ω	or Attend after death Director: /	Certification:	4 Homicide determined	building, etc		,		City or To	wn, State)		,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	(Check only 2 Medical Exemin	ner: On the basis of	f my knowledge, deat examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) a	and manner as place, and due	stated, to the cause(s)
	To the within 2	Med	29b. Signature and title of certifier	and manner stat	leu.	29c. Licens	e number		29d. Date	signed (Monti	h, Day, Year)
	⊢≯≓ŏ		Daniel AK IA	bistans -	1.410	Im	44373		6	1 /	07
•			30. Name d address of person who co	moleted cause of de	th (Itam 23a) (Type		17313		0/	ت ر ت	- /
1	HIVA					•	C	M- 1	1 0	1011	
	Sta	ate	Joseph K. Weidner, 31. Date filed (Month, Day, Year) JUN 1 9 2	32. P	Colonial r's Signature	way, Kis	ıng Sun,	mary⊥ar	ıa2	1911	
4	Regist	100	JUN T 8 5	007 Flore	New St Ja						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** BENJAMIN (0:20 PM June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical hound 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖸 F 216-56-6532 56 Director 26,1950 Sept. Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5 Granite Avenue 21904 or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify. ģ 3 Widowed 4 Divorced White natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. Ten Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Carl E. Shuler 2 Edith I. Eller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Benjamin (Husband) 5 Granite Avenue, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hopewell Cemetery 06/19/07 Port Deposit, Maryland 4 □ Qonation 5 □ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cumuc **Physician** Rat /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Examir burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Cther (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1-Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of pern who completed cause of death (Item 23a) (Type, Print) Medical Center 301 ST. Paul ST. Kalhmine Mercy 32. Registrar's Signature State

State Registrar

07-04580 Jaclyn B

Μŧ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 21131

n Bauer	1	- For State	Certifi	icate of L	Death		,,	Re	eg. No.		
hysicia		Registrar 1. Decedent's Name (First, Middle,Last)					2.	Date of Dear Month		Year	3. Time of Death
Examir			UER					June 15, 2	2007		1507 hrs
		4a. Facility Name (if not institution, give s			. City, Town, or Lo	cation of I	Death			een Ann	
		Rt. 213 & Clanahan Shop Ro	oad		Centreville				1		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under:	_			L H C	. Birthplace (State or or or or or or or or or or or or or
Director		215-96-8836 1 M	2 X F 40	Yrs.	World S Days	TIOUTO:		MARCH	6,19	6/	Country
	-	Usual Residence of Decedent									10d. Inside City Limits
any		10a. State 10b. County		wn or Locatio							1 X Yes 2 No
nd show	-	MD QUEEN A	ANNE CI	ENTREV]				- 1	IO- Oiti-o	n of What	
laryla 8a-f	Director	10e. Street and Number			10f. Zip Code 2161	7			iog. Citize	USA	Country
oith the Maryland 5 23a or 28a-f show s 2 notified at once.	声	306 NORTH COMME							. 14		American Indian, Black,
with ns 23 be no	ral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hispa s, specify Cuban, I	anic Origii Mexican, '	n? (Spe Puerto R	city Yes or N Rican, etc.)	0-	White, e	
or items	Funeral	1 Never Married 2 Married	1 Yes 2 X No		0 T No	an anifor			S	Specify: W	ATTE
after	by F	3 Widowed 4 X Divorced	or Dates		Yes 2 X No		ind of wo	ork done	. 1_		ness/Industry
hours afte "natural",	ed	15. Decedent's Education (Specify only	College (1-4 or 5+)	during mo	st of working life. [TON OC	use retire	ed)			
136 thin 72 ne. than " edical I	ompleted	Elementary/Secondary (0-12)	-0-	SELF-	EMPLOYED				CLI	EANING	G SERVICE
5-0036 led within 7 Hygiene. other than	E E	12 17. Father's Name (First, Middle, Last)	-0-	DDIII	11	8. Mother's	s Name ((First, Middle	Maiden S	Surname)	
filed all Hyged of the	Be C	RICHARD GEORGE BA	IIER			BETT	ry J	UNE WI	LLIA	MS	
21215-0036 Joint the Maryland Mental Hygiene. Mental Hygiene. marked other than "natural", or items 23a or 28a-f she ie event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street	and Num	ber or R	ural Route N	umber, Cit	y or Town,	State, Zip Code)
MD day	-	BETTY JUNE FOSTER	/ MOTHER	306 N	ORTH COM	MERC	E ST	., CEN	TREV	ILLE,	MD 21617 City or Town, State
_ = 5 5 5 5		20a. Method of Disposition	20b. Pl	ematory or oth	ition (Name of cem ner place)			Date			
ages later of later		1 X Burial 2 Cremation 3	CHES		LD CEMET			0-2007	1		ILLE, MD
altimore, mit. Pages I a partment of He portant: If it		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	ee	22. N	ame and Address	of Facility	FIN	& NEWN	AM F	UNERA	L HOME, P.A.
Baltin permit. P Departme Importar	1	17/2 / 0/21	/ /	4.00	A TIDE	TOTO O	CT	CENTL	'WV 11.	1.К. М	1) / [0]/
ysician	_	23a. Part I. Enter the disease, or compl	cations that caused the death.	Do not enter t	he mode of dying,	such as c	ardiac o	r respiratory a	arrest, sno	ck, or near	Between Onset and
/Medical	1	failure. List only one cause of ear	Chest and Abdominal In	juries							Death
Examine	1	or condition resulting in death)	Due to (or as a consequence of)):							
		Sequentially list conditions, b.	Due to (or as a consequence of	٠.							
	ine	I li ally, leading to milliodiate	Due to (or as a consequence or	<i>/</i> ·	·*						
	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
cuted ind transi	l iii										
e execian a	Medical	UNPENDED	AMENDED						100	d. Date of	deliven
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	1		23c. If yes, outcome of pregr		etal death 3	Ectop	ic pregna	ancy	23	Month	Day Year
68 certifi	2 2	past 12 months?	1 Live birth Pregnant at time of de	=	ther (Specify)						
cath c	Dhyeirian/	1 Yes 2 No 9 V Unknowr	5 01111101111								of death?
D. E			contributing to death but not re	esulting in the	underlying cause	given in F	Part I.				bute to the cause of death? Probably 4 Unknown
P.C	nan ac										
ds, equir	onia								utopsy	1	Were autopsy findings available orior to completion of cause of
COT law I	, page 2 should be								erformed? es 2		death? ✓ Yes 2 No
	ged ',				26.Plac	e of Deat	h (Check	only one)			
ician s certi	director,	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nurs	ing Home 5	Resid	dence 6	✔ Other: Scene
f Vit	10	1 ✓ Yes 2 No 27. Manner of Death		28b. Time o	f Injury 28c. Inj	ury at Wo	ork?	28d. Desci Driver at		njury occur	
n of ding Pt h.	e fune	1 Natural 5 Pending	28a. Date of Injury (Month Day Year) Jun 15, 2007	1453 hrs	1	Yes 2	√ No				
SiO Atten	by the	2 Accident Investiga	28e Place of Injury - At h	nome, farm, st	reet, factory, office	building,	etc.	T	Cintal		per or Rural Route Number, City
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death.	filled in	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine		d / Highwa	ay			Rt. 213 &	Clanaha	in Shop F	Road, Centreville, MD
lospit t hour	ly fill	4 Homicide 29a. Certifier Certifying Physic	- I - I - I - I - I - I - I - I - I - I	death ac	surred at the time	date and	place, ar	nd due to the	cause(s)	and manne	er as stated.
the 11 the F	completely	(Check only one) 29b. Agnature and title of certifier	er:On the best of my knowled er:On the basis of examination and manner stated.	and/or investi	gation, in my opinio	on, death	occurred	at the time,	uate and p	piaco, ana	
P.F.C	00	29b. Argnature and title of certifier	and mariner states.		29c. Licer	nse numb	er				ned (Month, Day, Year)
00	1	1/1/1/12	least)		0.0	C.M.E.			ال ا	ıne 16, 2	<u>2</u> 007
TH	Canal Canal	30. Name and address of person who	completed cause of death (Iter	m 23a)							
7	1	Laron Locke MD. Assi	stant Medical Examiner	111 Pe	nn Street, Balt	timore,	MD 21	1201			
/	⊆ Sta	te 31. Date filed (Month, Day, Year)	32. egistrar's Signa	ture	rack s						
Reg	gistr	11111 4 0 2	007 Blesver 1	KS AND							
DHMH 17 Rev	/ 1/2n	DOIVIE 01		ORIGIN	IAL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear \mathbf{P} M **Physician** 2007 20:27 TUNE 13 RUTH IRENE BALLENTINE /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTOWN KENT CHESTER RIVER HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F JANUARY 29, 1938 PENNSYLVANIA 69 Director 159-32-6339 Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City. Town or Location 10b. County or than "naturel", or Iteme 23a or 28a-f show the Modical Examiner must be notified at 1 TYes 2 No Director CHESTER MARYLAND QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number UNITED STATES 2642 CECIL DRIVE 21619 death w Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked othany Injury or other traumatic event Be DORIS A. MENGEL HAROLD M. PHEASANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY NORMAN BALLENTINE, JR/HUSBAND 2642 CECIL DRIVE, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JUNE 19. 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State 2007 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that a fixed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause deach line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) My Dodys plasia

Due to (or as a consequence of): Physician ijeavs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): ed by the attending physicien detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CUA, CHO, ATN, CKD, Sleep Aprica Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed Morbid Obesity, Arthritis, Osteoporosis 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2/ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 al or Attending P safter death. I Director: After t d in by the funera 1: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/14/07 5099'C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clestertour mo 21620 100 Brown St. Stoddard MD 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 18 2007

			For State Registrar	State	of Man	yland / Dep <i>Ce</i>	artment c rtificate			ental Hy	giene		07	2 11	35
			1. Decedent's Name (First, Middle,	Last)			,			2. Date of De Month	ath Day	,	Year	3. Time of De	
I	Physicia /Medic		JANICE CHIQUITA	BARNES						JUNE	15		2007	2:59	Ам
ř	Examin		4a. Facility Name (If not institution,		um <i>ber)</i>		4b. City, Tov	n, or Location	of Death		4c.	County	of Death		
			901 MONROE MANOE	ROAD			STEVEN	SVILLE			QU	JEEN	ANNI	E'S	
	Funeral			6. Sex	7. Age (n yrs. last birthday,	If Under 1 Y		er 24 Hrs. Min.	8. Date of Bi (Month, D	rth		9. Birth	place (State or Fo	oreign
	Director		220-14-0316	1 □ M 2 🛣 F		82 Yrs.	WOTTERS	ays		OCTOBER	18,	1924	NEW	JERSEY	
	ō		Usual Residence of Decedent											104 1-14-05-1	lanita.
	nylan how		10a. State 10b. County		1	0c. City, Town or L	ocation							10d. Inside City L 1 ☐ Yes 2]	
	B-1-8	cto	MARYLAND QUEEN	ANNE'S	5	STEVENSVI	LLE							1 [163 2]	AINO
	b the	Directo	10e. Street and Number				10f. Zip Co	de			10g. Citi	izen of V	What Cou	ntry?	
	h wit		901 MONROE MANOE	ROAD			2166	6			UNII	ED :	STAT	ES	
	hours after death with the Maryland tural', or Itams 23s or 28s-1 show al Examinational be notified at	Funeral	11. Marital Status	12. Was De Armed F	cedent Eve	er in U.S. 13.	Was Decedent	of Hispanic C	Origin? (Spe	cify Yes or N	0.		e - Ameri k, White	can Indian,	
9	after or Ita		1 Never Married 2 Marrie		2 2 No		1 ☐ Yes 2 🛣						WHI		
3	ours rail;	l by	3 XWidowed 4 ☐ Divorced	Year or			10100 20	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			3,000,11			
2-0036	72 h	Completed	15. Decedent' (Specify only highes	s Education	1)	16a. Dece	dent's Usual C kind of work of DO NOT use r	ccupation lone during me	ost of worki	ng	16b. K	ind of B	usiness/lr	ndustry	
2121	within 72 ene. then "na	n pi	Elementary/Secondary (0-12)	Ť	(1-4or 5+)			etired)					_		
2	Hygier other th	ပ္ပ	12			HOME	MAKER				OWN				
ב		Be	17. Father's Name (First, Middle, L	.ast)						(First, Middle		Suman	10)		
<u>x</u>	should be and Menta marked umatic ev	2	CHARLES W. CAMP							E. JUI					
Maryland	2 6 5		19a. Informant's Name/Relationsh				ing Address (S								
	1 and 2 Health tam 27		SHARON CAMERON/I	AUGHTER			PETINOT								
Se	of He		20a. Method of Disposition 1 Deliberation	3 Demoval from	n State	20b. Place of Disp cemetery, cre	osition (Name matory or othe	of r place)	JUN	E 17	20c. Lo	ocation ·	City or T	own, State	
Ĕ	Pages nent of ant: If it ury or o		4 □Donation 5 □ Other (Sp		/	CHESAPEA	KE CREM	ATION	200	07	STEV	ENS	VILLI	E, MARYL	AND
altimore,	permit. Pages Department of H Important: If its eny injury or of once.		21. Signature of Funeral Service I	icensee	7	F	2. Name and A	ddress of Fac	NBEIN	AND NI	EWNAM	ı FU	NERAI	HOME,	P.A.
m	80559		23a. Part1. Enter the disease, or shock, or heart failure. List	- 10	1	<u> ' </u>	06 SHAM	ROCK R	OAD.	CHESTE	R. MA	RYL	AND :	21619	
8760,	Physician /Medical Examiner but stipe parial-transit stipe purial-transit stipe private parial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due t	o (or as a o	consequence of):	B TRUL	CTIVE	NO	MONA	7ay	DISA	ASE		
Division of Vital Records, P.O. Box 687	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		birth 2 gnant at tir	Fetal death 3	⊒Ectopic pregi ⊒ Other <i>(speci</i>		~ /A				ate of definanth	Very Aye	år
rds, P	w requires that been signed b should be deta		Part II. Other significant condition	ns contributing to	death but	not resulting in the	underlying cau	se given in Pa	rt I.		1	use con		the cause of dea	
Reco	The law re te has bee	Completed								24a. Wha auto per 1 \(\text{Yes}	s an opsy formed?		Were aut prior to c death? 1 \(\sum \text{Yes}	opsy findings avon	ailable se of
ta	an: rtifice stor. p	Bec	25. Was case referred to medical	The same of the sa				26. Pia	ace of Death	(Check only	one)				
>	ysici is ce direc	ToE	examiner? 1 ☐ Yes > No	Hospital:	☐ Inpatient	2 ER/Outpatie	ent 3 DOA	Other: 4 🗆	Nursing Ho	me Ke	sidence	6 □Oth	ner (Spec	ify)	
o uo	nding Ph th. :: After th e funeral	ation; 1	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9 <i>(M</i>	te of Injury onth, Day	/ear) 28b. Time Injury	of 28c	Injury at Work? 1 \(\text{Yes} \) 2	_	28d. Describe	how inju	ry occui	rred		
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 288. Pla	ce of Injury fding, etc.	y - At home, farm, s (Specify)	treet, factory, o	ffice		28f. Location City or T	(Street allown, State	nd Numi a)	ber or Ru	ral Route Numbe	37,
	ne Hospit n 24 hour ne Funera	Medical (Exeminer: On the		my knowledge, dea xamination and/or i d.									
	To the	ž	29b. Signature and title of certifie	4.00	74.	10		icense numbe						, Day, Year)	
1	AD		1 nomes	Walstr	- M	U	1	238	6/		6	-15	07	7	
	15)		30. Name and address of person	who completed ca	use of dea	ith (Item 23a) (Type	Print)	Driv	e St	evensi	nlle	1	10	2166	6
	Sta Regist		31. Date filed (Month, Day, Year)		. Registrar	s Signature	hard .					7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 5:40 A.M 2007 17, June James Donald Blair /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 68 June 15, 1939 PΑ 206-28-3897 **Director** Usual Residence of Decedent 10c, City, Town or Location 10d, Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 20874 19321 Hottinger Circle United States Funeral death. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examine 1 □ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: δ 3 ☐ Widowed 4 ☐ Divorced 1969 Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roberta Confer Blair Clarence Henry ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19321 Hottinger Circle, Germantown, MD. 20874 Ann Emily Blair/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 6/17/2007 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Euneral Service Licensee Lui 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Respiratory Failure weeks disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Severe Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Meningioma (2/07) with resection, Hypertension, 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypothyroidism, Legionella pneumonia (5/07), Reflux 24a. Was an nas e 2 certificate has irector, page 2 autopsy performed? 1□ Yes 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ∏Yes 2 ∏No investigation s after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide within 24 hours aff

To the Funeral D

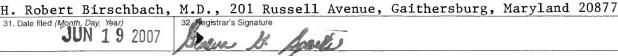
completely filled in the Hospitai 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 31. Date filed (Month, Day, Year) JUN 1 9 2007

Ne Retert Birschly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



cleral. D 04115

29d. Date signed (Month, Day, Year)

June 17, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician Burns Pauline Agnes June 13 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury 6170 Westbury Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 XF 189-32-0988 83 5/12/1924 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel", or itema 23a or 28a-i show the Medical Examiner must be notified at 1 Yes 2 No Wicomico Salisbury Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 6170 Westbury Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: white ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Domestic 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Anna Novak Samuel Evans 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tra 6170 Westbury Drive, Salisbury, MD 21801 Terry Burns/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Crift Cemetery 6/19/07 Linwood, PA 22 Name and Address of Facility HOITOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 of Funeral Service Licenses compone CFSF 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** moman /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed 44 hours after death. physicien and the burial-transit Exami Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home \5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ Pis funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D 00 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Piyush Mehta Shone 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 18

ORIGINAL

			For State	State of Maryland	d / Department of Certificate of			- 211117	7143
	٥		Registrar 1. Decedent's Name (First, Middle, Lace	3	O 1/1	Deam	2. Date of Dea		3. Time of Death
	Physici /Media	al.	JANICER	asola	Barkle	2 Y	JUNE	9, 2007	1935 (PM)
	Examir	er	4a. Facility Name (If not institution, give	100 11	1 101	n, or Location of Peath	md	4c. County of Death	ster
	Funeral Director		200 00 1160				8. Date of Birth (Month, Day	y Year) 9. Birthe Cour	place (State or Foreign ontry) The Carolina
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			1	10d. Inside City Limits
	Ba-f sh	Director	Md Word	ester SN	Jow Hi	LL			1 Tyes 2 No
	with the	Dire	10e. Street and Number	Strept	10f. Zip Cod	263		10g. Citizen of What Cour	itry?
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland stal Hygiene. Individual then "naturel", or Items 23e or 28a-f show event, if a Medical Evar, it ar must be I ceithed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dales:	1 □ Yes 2	1	,	Specify: BL	ACK
2-00	72 hounature	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Decedent's Usual Oc (Give kind of work do	ne during most of wor	king	16b. Kind of Business/In	dustry Nursing
121	within 72 ene. then "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NUTCE	tired)		Methodi	1 1
nd 2	be filed within tal Hygiene. d other then	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
Maryland 21215-0036	should be and Mental s marked o umatic eve	To I	Johnny Mo		19b. Mailing Address (Stro	Lale	a R	Bolden	Code
	lith ar 27 is r treu		Kaleemah Ba	. (1)	5606 Moat	01/	11.55	Md 2186	19
Baltimore,	Pages 1 al		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐	nemoval hom State	ace of Disposition (Name of metery, crematory or other)		Date	20c. Location - City or To	4
Ħ			* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens	mt.	21 Name and Ad		6/01	> Now HI	II Md
Ba	permit. Departn Importe ser inju		100	110	22. Name and Ad Bennie Funero	2) Home	911	Salisbury	md 2180/
	*		shock or heart failure. List only o	lications that caused the death. one cause on each line.	. Do not enter the mode of	dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	entia		· · · · · · · · · · · · · · · · · · ·		7-yes.
	Examiner		Sequentially list conditions,	b	0.100 017.				
	ted sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
o,	cate be executed ohysician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):				
8760	cate be ohysicia the bu	dicai		d.					
Box 6	eath certific attending p I for use as:	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Date of deliv	өгу
	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown				Month	Day Year
P.0	that the de led by the detached	y Phy	Part II. Other significant conditions co	ontributing to death but not resul	lting in the underlying cause	given in Part I.	23e. Did to	obacco use contribute to t	he cause of death?
rds	w requires been sign should be	ed by					1 🗆 1	res 2 No 3 Prot	bably 4 □Unknown
Records,	has bei	Completed					24a. Was autop	an 24b. Were auto prior to co med? death?	opsy findings available ompletion of cause of
Vital F		e Cor	25. Was case referred to medical			26 Place of Dea	1 ☐ Yes	2 No 1 Yes	2 No
of Vil	Physicien: rthis certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ENOutpatient 3 DOA	Other: 4 Nursing H		dence 6 ☐Other (Specia	fy)
o uc	ling After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		njury at Work? 1 □ Yes 2 □ No	28d. Describe h	now injury occurred	
Division	deat deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, street, factory, offi		28f. Location (S City or Tov	Street and Number or Run	al Route Number,
ā	oitel or urs afte orel Dir illed in								
	To the Hospitel or Atten within 24 hours after deat 76 the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physical Example one)	ysician: To the best of my know niner: On the basis of examination and manner stated.	viedge, death occurred at thi ion and/or investigation, in n	e time, date and place ny opinion, death occu	rred at the time,	cause(s) and manner as s date and place, and due t	o the cause(s)
	To the within to the composite of the co	Me	29b. Signature and title of certifier		λ.	ense number		29d. Date signed (Month,	
,	J Lugh		20 Name and address (SARAD R. BA	4R AL: MO) D	54422		109/me	2007
0	/		30. Name and address of person who of 1604 - Market	St. Ponom	with MI	21851			
•	Sta Regist		31. Date filed (Month, Cay, Year) 2	32. Registrar's Signatu	of factor				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 0 Banks 11295. /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDICAL LENTER ENINSULA PALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔾 F 11-05 Director Usual Besidence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director COMIC MAN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2185 5934 Funera Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 KESTAURANT 00 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RES SSAC ORNISH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUSBURY MD 2/80)
20c. Location - Gity or Town, State NEULIE HAYMAN ~ NIECE 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State ZION UM Ch. MD 4 ☐ Donation 5 ☐ Other (Specify) EM 21. Signature of Funeral Service Licensee ENNIE MD ISABELLA 2180 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumoni **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine plat, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perfo certificate 1∏ Yes mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 No ၉ 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Name of the cause (s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and MARINE

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

116

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 06-25-2007 22:20 Daniel Coxe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland 213 Maryland Avenue If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 M 2 F May 24, МD 1939 Director 220-38-6136 68 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County r 28a-f show notified at 1√Yes 2 No Cumberland Allegany Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 1 21502 USA 213 Maryland Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □**X**o Maryland 21215-0036 þ 3 Widowed W Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cumb. Times-News 12 writer marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oftwany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Helen C. Rankin Coxe Daniel R. Coxe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26726 Rt. 2 Box 130 Keyser Robert Keeler friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 7/2/2007 MD Flintstone 4 □ Donation _ 5 □ Other (Specify) 21. Signature Fineral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ate Cause (Final diseas or condition resulting in death) RS **Physician** COPD with medical complications /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Box 68760. Due to (or as a consequence of): Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death P.O. | ed by the a detached f 9☐ Unknown 9 Unknown ate has been signed l page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. à 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA P After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address a ZRD ST. CUMBERLAND, MD 21502 124 W. 32 Registrar's Signature State 31. Date filed (Month, Registrar

Division or Vital Records, P.O. Box 68760, this

eral Director; After th filled in by the funeral

၉ Certification:

Medical

To the Hospital o within 24 hours aft To the Funeral Di completely filled in State Registrar 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D0064208

SILVERSPRING

MD 20906

thisem

HUSAIN 3227 BELPRE ROAD. 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	waiyia		ertifica)		Reg. No	011177	21443
	Physici /Medic		Decedent's Name (First) JOYCE	, Middle, Last)		CHA	ANDLER					Date of De Month	ath Da		3. Time of Death 12 45 A M
•	Examin		4a. Facility Name (If not in:					LAN	HAM	r Location			P	C. County of Death	
	Funeral Director		5. Social Security Number 179–34–9721	1 🗆	M 2 □ ¥F	7. Age (In yr. 64	s. last birtha Yrs	Month	ler 1 Year s Days	If Under Hours	r 24 Hrs. 8 Min.	3. Date of Bir (Month, Da 04-21-	th ly, Year -194	9. Birth Cod PENN	nplace (State or Foreign untry) ISYLVANIA
	tryland thow	_		County			City, Town o	r Location							10d. Inside City Limits 1 X Yes 2 □ No
	ne Ma Ba-f s otified	ecto		INCE GE	ORGE	LAN	NHAM	106	Zip Code				10a C	itizen of What Co	
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 6901 WOODST					2	0706				U.	S.A.	
YCE 036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☒ D	☐ Married ivorced	2. Was Dece Armed For 1 Tes If Yes, Give Year or Da	dent Ever in ces? 22.No etes:	U.S.			lispanic O an, Mexica Specify		ify Yes or No ican, etc.))-	14. Race - Amer Black, White Specify: BL	
$\sqrt{0 \%}$	ithin 72 ho ne. nan "natul e Medical	npleted	15. D (Specify only Elementary/Secondary	ecedent's Educ y highest grade (0-12)	Completed) College (1-	-4or 5+)	16a. Do		sual Occup work done use retire CHER	pation during mo d)	st of working	7	Ì	Kind of Business/	
	led w lygiel her tl		17. Father's Name (First,	Middle Last)	4yr	<u> </u>		ILA	CHEK	18 Moth	ner's Name	First. Middle	. Maide	en Surname)	
(C・K Maryland	uld be fi fental H rked ot tic ever	To Be	ELROY GRAVE							1	DA JOR			,	
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Re	elationship (Typ	e. Print)			-						or Town, State, Z	Zip Code)
	4 17 ± 4		MICHELLE CH 20a, Method of Disposition	<u> </u>	DAUGHT		. Place of D			K DR	GREEN	BELT,		20770 Location - City or	Town, State
hand Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.	1	1 X Burial 2 □ Crer 4 □ Donation 5 □ C	mation 3 □Re Other (<i>Specify)</i>		State	cemetery,	crematory o VET C	or other pla EMETE	RY	6-22-		WAS	SHINGTON,	, DC
Balt	permit Depart Import any In		21. Signature of Funeral S	. M-	has	11		7474	LANDC	VER 1	RD LAN	DOVER	, MD	NERAL HO 20785)FIE
	Physician		23a. Part1. Enter the disc shock, or heart failu Immediate Cause (Final	ease, complic re. est only on	eations that ca e cause on ea							respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Ca.		or as a cons	e unce of)		~ (wall	<i></i>				
		ner	Sequentially list condition if any leadin, to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	s, b.		as a cons	equence of)	:							UTK
Ć.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a cons	equence of)	:							
68760,	flicate be g physicia ts the bur	edical		d											
Box	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant		irth 2□F ant at time o	etal death	3□Ectopie 5□Other		Э				23d. Date of del Month	livery Day Year
ds, P.	uires that t signed by id be deta	र्व	Part II. Other significant	conditions con	tributing to de	eath but not r	esulting in t	ne underlyin	g cause gi	ven in Par	t I.				o the cause of death?
Division or Vital Records, P.O.	rhe law require e has been sig age 2 should b	Completed										24a. Was auto perl 1□ Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
ita	ian: rtifical stor, p	Be	25. Was case referred to	medical						26. Pla	ce of Death	Check onl			
> _	Physician: The le rithis certificate har ral director, page 2	10E	examiner? 1 ☐ Yes 2 ☑ No	Н		<u> </u>	□ ER/Outp		DUA					6 □Other (Spe	ecify)
on G	ding Ph n. After th funeral			Pending investigation	28a. Date (Mont	of Injury th, Day Year	28b. Tir Inji			ıryat ork?]Yes 2[8d. Describe	how in	jury occurred	
Divisio	pltal or Attencours after death ours after death reral Director; filled in by the	rtificat	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place buildi	of injury - A ng, etc. (Spe	t home, farn ecify)					8f. Location City or To			ural Route Number,
	spital	Medical Certification:	29a. Certifier 1 🗓 (Check only 2 🗍 one)	Certifying Phys Medical Examir	ner: On the b	best of my lasis of exam	knowledge, ination and	death occur or investiga	red at the t	time, date opinion, d	and place, a feath occurre	and due to the	e cause e, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hos within 24 hor To the Function	Med	29b. Signature and title o	f certifier	and main	. stateu.			29c. Licen	se numbe	er		29d. l	Date signed (Mon	th, Day, Year)
	10		▶ Rit	R	- M.				0.	4344	G			6.16.0	7
	B)		30. Name and address of			e of death (I	tem 23a) (T	ype, Print)	Avi.	Suit I	3-41	Silva		pring M.	D 26902
		ate	31 Data filed (Month) B	Year)	A H1 (- 6	egistrar s 3	TO STATE OF	70						1	
	Regist	rar	3011 T 2 500	Likai	LOW A	and the same	12								

Registrar

2. Date of Death 1. Decadent's Name (First, Middle, Last) **Physician** USACK SHN 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 81 404-26-7141 Director Feb 20, 1926 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Lethian Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3 184 Boones Drive 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; I frem 27 is marked other than "natural", or ite any injury or other traumatic event, the M dival Examine 1 Yes 2 No If Tes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Gov't Elementary/Secondary (0-12) College (1-4or 5+) Smithsonian Institute Restorer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Cusack, Sr. Rose Mary Waldhier ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Cusack (wife) 184 Boones Drive Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Jun 22 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 4 Donation 5 Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cary J. Gorf 8125 Southern Maryland Blvd. 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner + Onel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): signed by the attending physician does detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes Completed 24a. Was an 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3 □ DOA this 28b. Time of 27. Manner of Death . Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Cheltenham, MD Lee Funeral Home Calvert, PA Owings, MD 20736 Approximate Interval Between Onset and Death ul 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 No Nown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) HIGHWAY

3. Time of Death

0135

9. Birthplace (State or Foreign Country) Kentucky

White

10d. Inside City Limits

1 ☐ Yes 2X No

15 Registrar

Director

24 hours a

To the I within 2.

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

Name and address of person

31. Date filed (Month, Day,

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

2007

no completed cause of death (Item 23a) (Type, Print)

32. Registras Signature

1 ☐ Yes 2 ☐ No

29c. License number

			State of Maryland / Dep	partment of Hea ertificate of De			0007	0111			
1	37		Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of De	zaui	2. Date of Deat	eg. No.	3. Time of Death			
	Physici /Medi		Ronald Carpenter			June 13,	Day Year	2:04 P M			
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of		4c. County of Death	2.04 F			
and the			Holy Cross Hospital	Silver S			Montgome	ery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F		Under 24 Hours	Min. (Month, Day,	Year) Cour	olace (State or Foreign ntry)			
21	Director		578-56-5339 SW 2DF 65 Yrs. Usual Residence of Decedent			Aug. 6,	1941 Washi	Ington, D.C.			
	ylanc how at		10a. State 10b. County 10c. City, Town or I	.ocation			1	10d. Inside City Limits			
	e Mar Ba-f sl tified	ctor	DC N/A Washin	gton				1 MgYes 2 □ No			
	vith th	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Cour	ntry?			
	eath v	eral	4916 Kansas Avenue, N.W. 11. Marital Status 12. Was Decedent Ever in U.S. 13	20011		-0.40 - 14 - 14	U.S.	I			
_	fter d r item iner	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	. Was Decedent of Hispar If Yes, specify Cuban, M	dexican,	Puerto Rican, etc.)	14. Race - Americ Black, White,				
3	ursa al",o Exam	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Sp	Specify:		Specify: Bla	ıck			
9500-61212	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done durin	n na most a	of working	16b. Kind of Business/In	dustry			
7	within iene. • than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			Dwivete Tulustus				
	e filed val Hygie I other t vent, th		12 Comp 17. Father's Name (First, Middle, Last)	uter Program		s Name (First, Middle, M	Private Ind	ustry			
/land	ould be to the model of the marked or the ma	To Be	Caesar A. Carpenter			ine Wills	raideri Surriame)				
ar Z	should band Ment s marked umatic e	F		ling Address (Street and I			City or Town, State, Zip	Code)			
, Mar	and 2 alth a 27 is			Cruet Lane,				,			
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev once.			osition (Name of ematory or other place)			20c. Location - City or To	uwn, State			
Ĕ	. Pag ment tant; I		4 □ Donation 5 □ Other (Specify) Chesapea	ke Cremator	y Ju	ne 19, 2007	Beltsvil	le. MD			
ga	Depar Mpor Iny in		21. Signature of Funeral Service Licensee	22. Name and Address of	f Facility	McGuire Fu	neral Servi	ce, Inc.			
	HD = 10 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Medical Approximate Interval Between Onset and Death Due to (or as a consequence of):									
	Physician /Medical										
	Examiner										
		ner									
	ecute ind transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	port Line Se	epsi	S					
0/00,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of): Acute on Chronic	Popol Foilu	**						
00	icate physi s the	dical	d. Acute on chronic	Kellal Fallu	TE						
Š	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				, 23d. Date of delive	201			
	death e atte	icia	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 1 ☐ Yes 2 ☐ No. 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>				Day Year			
5	at the by th tache	hys	9 □ Unknown								
<u>ה</u>	res tha	ρχ	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in	Part I.	23e. Did tob	acco use contribute to th	ie cause of death?			
Ö Ö	requi	ted				1 _ Ye	s 2 <mark>;</mark> No 3∏ Prob	ably 4 Unknown			
ה ה	e law has b e 2 st	Completed				24a. Was an autopsy	/ prior to cor	psy findings available mpletion of cause of			
<u> </u>	n: Th ficate r, pag					perform 1□ Yes 2		2□ No			
=	sicial certii recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ FR/Outpatient	Othor		f Death (Check only one					
5	g Phy er this eral d	ت 1	27. Manner of Death 28a. Date of Injury 28b. Time of	IN SU BOA 4	4 ∐ Nursi	ing Home 5 Resider	nce 6 Other (Specify w Injury occurred	0			
2	ath. r: Aft	atio	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes	2 □ No						
2	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,			
2	ital o						·				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or i	h occurred at the time, dancestigation, in my opinion	date and pon, death	place, and due to the ca occurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)			
	o the o the o the o the o the o the o the	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License num	mber	29	d. Date signed (Month, i	Day Year)			
	⊢s⊢ő		Saima Chanaga								
•	5	}	30. Name and address of person who completed cause of death (item 23a) (Type	D005896	0.5	J	une 14, 200	/			
			11119 Rockville Pike, Suite 100 Rock	,	0852	Dr. Sai	ma Khawaja				
議	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Registra	ir	JUN 1 9 2007 Janear &	perke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. D'ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 650M /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lisbury HOSPIC e ou Me Gastal If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1**x** M 2 □ F 8/21/1942 Director 217-42-0085 64 Kansas Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2X No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 2241 St. Lukes Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2【 No Specify. 3 Widowed 4 □ Divorced Year or Dates: white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 E.I. DuPont Co. asbestos worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Is marked otl Dorothea Soderlund Frederick Stanley Cowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health Heidi J. Oliver/daughter 9309 View Court, Frederick, MD 21701 Department of Health Important; If item 27 any injury or other tr 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 6/15/07 Salisbury, MD 21. Signature of Funeral Service License ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hronk /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 0 9 Unknown ۵. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Impatient မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Hospital or Attending 5 ☐ Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

Bx1733 Salish, MD 21802

and manner stated.

30. Name and address of person who completed cause a death (Item 23a) (Type, Print)

		•	1 - For State Registrar	State of Mai	-	artment of F			giene 00	7 21447
×	Physici		Decedent's Name (First, Middle, Last) ROY		IZE			2. Date of Dea Month June	th Day Year	3. Time of Death 8:10 P M
	/Medic Examin		4a. Facility Name (If not institution, give : Alice Byrd Tawes N	street and number)		4b. City, Town, o			4c. County of De Somers	
	Funeral Director		213-14-3431	7. Age	(In yrs. last birthday 88 Yrs.	If Under 1 Year Months Days		lrs. 8. Date of Birth lin. (Month Day Jan. 14,	9. B 1919 Ma	irthplace (State or Foreign Country) ryland
e e constituir de la co	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Somers		10c. City, Town or L	ocation Crisfiel	đ			10d. Inside City Limits 1X Yes 2 □ No
	3e or 28e	Funeral Director	10e. Street and Number 6 Standard Avenue			10f, Zip Code	21817		10g. Citizen of What (Country? S.A.
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh Specify: Wh	
Maryland 21215-0036	within 72 hou iene. than "nature than "nature in in made in its ma	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of		16b. Kind of Busines	s/Industry cking Company
land 2	ould be filed went Hygid arked other atic event, It	To Be Co	17. Father's Name (First, Middle, Last) A. Earl Dize				18. Mother's i	Name (First, Middle,		
	es 1 and 2 should be of Health and Mental I Item 27 is marked r other traumatic ev		19a. Informant's Name/Relationship (Ty John Dize (Cousin)	pe, Print)	6 St	andard Av		Crisfield		7
Baltimore,	permit. Pages 1 Department of H. Important: If Itel any Injury or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Sunnyridge	Memorial P	ark 6/	²⁰ /07	20c. Location - City of Crisfield	
Bal	permit Depar Impor any In		21. Signatur of Funery's prior Lights Robert H. brads 23a. Part. Enter the disease, or comple	haw or.	B 3	06 W. Mai	Sons F n St	uneral Hor Crisfield	, MD 2181	7 Approxi <i>m</i> ate
8760,	death certificate be executed Wedical e attending physicien and dor use as the burial-fransit	icai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of the denying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	consequence of): consequence of): consequence of):	ASCV) 1			Interval Between Onset and Death
O. Box 6	that the death certific ted by the attending p detached for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of o Month	lelivery Day Year
rds, P.	v requires that i been signed by should be deta	۵	Part II. Other significant conditions col	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	<u> </u>	to the cause of death? Probably 4 Unknown
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was autop perfor 1 \(\text{Yes}	sy prior t med? death	autopsy findings available o completion of cause of ? es 2□ No
Vita	Physician: 7 this certifical ral director, p	Be C	25. Was case referred to medical examiner?	lospital:	• a□ = B/O	ot pos lot		Death Check only o		
	ding h. After fune	ation: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day	t 2 □ ER/Outpati 28b. Time Year) Injury	of 28c. Inju	4 Nursin		lence 6 □Other (S) now injury occurred	эвспу)
Division	tal or Attenders after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, far <i>m, s</i> (Specify)	treet, factory, office		28f. Location (S City or Tou	Street and Number or m, State)	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	ledical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or	nvestigation, in my	opinion, death o	ccurred at the time,	date and place, and d	ue to the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of certifier	1+0	7	D	se number 48098	-	29d. Date signed (Mo	T
+ /	EB		30. Name and address of person who of Vijay Karumbunath	an, M.D	- 201 Hali		- Cris	field, MD	21817	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 0 2	32. Registrar		Smarth ,				

			1 - State Registrar	e of Maryland / Depa Cer	artment of Health ar rtificate of Death		giene 0 0 7 2 1 1, 1, 5
			Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th 3. Time of Death
	Physici /Medic		DOLORES E.	DEAN		June	21, 2007 9:15 P M
	Examir		4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or Location of	Death	4c. County of Death
			McCready Memorial Hos	spital	Crisfield		Somerset
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 25	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day) Feb. 9,	y, Year) 9. Birthplace (State or Foreign Country) 1929 Maryland
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Maryis 3a-f sho	ctor	Maryland Somerset		field		1 ☐ Yes 2 🖾 No
	th with th	al Director	10e. Street and Number 4970 Joshua Thomas Roa	ad	10f. Zip Code 21817	1	10g. Citizen of What Country? U⋅S⋅A⋅
21215-0036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show salical Examinations I be motified at	by Funeral	1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Ma	ed Forces?	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I 1 ☐ Yes 2 ☐ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0	72 h	Completed by	 Decedent's Education (Specify only highest grade comp 	eted) 16a. Deced	dent's Usual Occupation kind of work done during most o DO NOT use retired)	of working	16b. Kind of Business/Industry
121	within ene. than "	mpl		ege (1-4or 5+)	no not use retired) keeper		Construction
2	filed withii Hygiene. other than ent, Ille M		12 17. Father's Name (First, Middle, Last)	BOOK		s Name (First, Middle,	
Maryland	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 Is marked other than "netun or other traumatic event, the Medical	To Be	C. George Renstrom		Eli	izabeth Bed	ldoe
Mar	12 sh h and 7 Is m rraum		19a. Informant's Name/Relationship (Type, Prin Roland Dean (Husband)				r, City or Town, State, Zip Code)
	of Health of Health litem 27		20a, Method of Disposition	20b. Place of Dispo	Joshua Thomas		field, MD 21817 20c. Location - City or Town, State
nor	Pages nent of I int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery, crer	natory or other place)	6/22/07	Salisbury, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Fun val Service Lieusee	22 B	Name and Address of Facility radshaw & Sons	Funeral Ho	ome
	402 e 0		Robert H. Bradshaw 23a. Part1. Enter the disease, or complications	Jr. 3	06 W. Main St.	- Crisfiel	d, MD 21817
	Physician /Medical		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	ue to (or as a consequence of):	Em My	sem A	Interval Between Ons t and Leath
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of):			
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	s that ned b e deta	by Pt	Part II. Other significant conditions contributing	g to death but not resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
rds	w requires t been signe should be					1 🖫 🗡	es 2 No 3 Probably 4 Unknown
Records,	The law requirate has been page 2 should	Completed				24a. Was a autops perfor	sy prior to completion of cause of
Vital		Be C	25. Was case referred to medical examiner?		26. Place o	of Death (Check only or	
of V	lis dii	To	1 Yes 2 No Hospital	1 Impatient 2 EN Outpatier	t 3□ DOA Other: 4□ Nurs	ing Home 5 Resid	ence 6 Other (Specify)
	nding Ph ath. r: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	28c, Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No.}\)		ow injury occurred
Division	al or Atte after de: Directo d in by th	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (S City or Town	itreet and Number or Rural Route Number, n, State)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in d manner stated.			rause(s) and manner as stated. date and place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	Ous us	29c. License number D 39813	2	29d. Date signed (<i>Month, Day, Year</i>) June 22, 2007
			30. Name and address of person who complete	d cause of death (Item 23a) (Type,	Print)		
)	0+1 EB		Michael Atkins, M.D.		nway- Crisfield	MD 2181	7
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			
DLI	Registr	4-1	JUN 2 2 200	Blan &	April .		
υH	MH 17 Rev 1/2	UUI	-	ORIGINA	W - 1		

			1 - For State Registrar	State of	Marylar			nt of H te of L			ental Hy	giene	. UU/	21449
	Dhysiai	22	Decedent's Name (First, Middle		_						2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio		Ralph	Donalds	Sr.						June		2007	10:05 P
-	Examin	er	4a. Fecility Name (If not institution	-	oer)				Location of	of Death			County of Deat	
			621 South Cam					Fruit		04.11			Wicomic	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F		last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D			nplace (State or Foreign untry)
ч	Director		218-20-7994 Usuel Residence of Decedent		80			li			9/19/	1926	Ma	ryland
	yland now		10a. State 10b. County		10c. Cit	ly, Town or Lo	cation							10d. Inside City Limits
	Mar Fed	tor	Maryland Wico	mico	Fr	uitlan	d							YOS 2 ☐ No
	or 28	lrec	10e. Street and Number					p Code				10g. Citi	zen of What Co	untry?
	23a c	aiD	621 South Cam	den Ave.				21826	,				USA	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow fre Medical Exaciliyar maral be notified at	Funeral Director	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Dece f Yes, spe	edent of His	spanic Origin, Mexican	gin? (Spe n, Puerto f	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 21 Marri 3 ☐ Widowed 4 ☐ Divorced	If Tes. Give	□No		1 🗆 Yes		Specify:				Specify:	
8	hour	pa pa	15. Decedent	Year or Date	9S: 1	16a. Dece	dent's He	al Occupa	tion			16h Ki	M nd of Business/	hite
15	n "na	piet	(Specify only highes	t grade completed)		(Give	kind of w	ork done d use retired)	urina most	t of workin	ng	100. KI	nd or businessy	ndustry
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Owne	r/op	erato	r			Ma	sonry	
פ	other vent,	BeC	17. Father's Name (First, Middle, I	Last)						r's Name	(First, Middle	, Maiden	Sumame)	
/lai	Vid b Ment	10	Omar Donalds						Eug	genia	Walte	rs		
Maryland 21215-0036	and and le mu		19a. Informant's Name/Relationsh			1	-					-	Town, State, Z	
≥	and eelth m 27 her tr		Mae Belle Dona	las/wile					maen				d, MD 2	
Baltimore,	if of H		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation		ate	Place of Dispo	natory or	other place			ate		cation - City or	
Ħ	t. Pe ntmen rtant: njury		4 Oonation 5 Other (Sp	1) Pa:	comico			,	6/15,		_	lisbury	
Bal	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiane. Important: if Item 27 is marked other than "natural; or items 23a or 28e-f show any futury or other treumatic event, the Medical Exacilinar near ite notified at once.		21. Signature of Funeral Source L	Licensee /		H	ollo	nd Address Way F	s of Facility uner	ăl Ho	me Pro	fess	ional A	ssociation
			25a. Part1. Enter the disease, or	complications that cau	sed the day								MD 218	J4 Approximate
			hock, or heart failure. List of Immediate Cause (Final	only one cause on eac	h lie		_		_		rospiratory e			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	as a conseq	· C	Lun	5	- Le	21				17000
	Examiner				as a conseq	derice or,								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):								·
	cuted	ami	that initiated events	c										
Ő,	rate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or	as a conseq	uence of):								
8760,	The law requires that the death certificate be executed the hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner		d									-	
9 ×	that the death certific ed by the ettending p detached for use as	/Me	IF FEMALE:	220 If was outpo	mo of program									
Box	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?		n 2 □ Feta It at time of d	Ideath 3		regnancy				1 2	23d. Date of deli Month	very Day Year
P.O.	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		eatii 5	Other (s	оөсіту)				}		
	that ned by deta	F P	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did	obacco u	se contribute to	the cause of death?
rds	w requires that been signed to should be det	d by									1150	Yes 2[□No 3□Pro	bably 4 Unknown
Ö	s bee	jete									24a. Was	an	24b. Were au	oosy findings available
æ	The lay te hes age 2	Completed									auto	psy ormaed}r	death?	opsy findings available ompletion of cause of
a		0	25. Was case referred to medical						26. Place	of Death	Check only	2 X No	1 Yes	2 No
>	Phyeici this ce al direc	ToB	examiner? NDMes 2 □ No	Hospital: 1 Inp	atient 2	ER/Outpatien	t 3 🗆 D	OA Othe					S □Other (Spec	ufy)
0	Attending Physician: r death. sctor: After this certifice by the funeral director, g	ä	27. Manner of Death 1 KNatural 5 ☐ Pending	28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury Work	at ?		8d. Describe			
Sio	eath. or: A	catic	2 Accident investig	ation		, , ,	М		'es 2 □ h	No				
_	Irec of Irec	Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 288. Place of	Injury · At he , etc. (Specify	ome, farm, str y)	et, factor	y, office		2	8f. Location (City or To	Street and wn, State,	d Number or Ru	ral Route Number,
	pital orel [2	29a. Certifier 1 Certifyin	Dhiminian To the he	not of any leave	and the second second			us again and	A DECEMBER OF THE	orbandan hirinan basala	C 200 71 404		
	Hos 24 hc Fun etely	dicai	(Check only 2 Medical E	Physician: To the be xaminer: On the basi and magner	s of examina	tion and/or inv	estigation	i, in my op	inion, deat	th occurre	d at the time,	date and	place, and due	to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	2				c. License					e signed (Month	
	lan		1/6.	/	- 1	10		0	306	90		50	~ 13	2007
1	Dur		30. Name a address of person v	who completed cause of	of death (Item	23a) (Type,	Print)						, ,	2007 7, MD.
7	1000		/	MARTIN	MO	,14.	5 E	. <	2000	11 5	7.	50	1:550	7 MD.
	Sta Registra		31. Date filed (Month, Day, Year) JUN 1 4	2007 32. Reg	istrar's Signa	ture					,			
	legisti		JUNIT	4001	ance 1	Or De	DAG!	P						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** DOROTHY 06 26 ELINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 7, 1928 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2□F Director 217-28-0069 78 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location r 28a-f show notified at Allegany Cumberland MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be I 21502 16 Weber Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married X ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leah Getson Jacob Getson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 \N/eher Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Robert Eline Sr. husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 6/30/2007 LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funere Service Licer/see 108 Virginia Avenue: Cumberland, MD 21502 23.1 Pint. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes ₽ No Nopatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Year)

03

Kent

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

2100

9. Birthplace (State or Foreign Country)

10d, Inside City Limits

↓ □ Yes 2 □ No

MD

Approximate Interval Between Onset and Death

2007

USA

Month

Black, White, etc.

State Registrar DHMH 17 Rev 1/2001

3

29c. License number

			1- State of Maryland State of Maryland		artment of F			giene Reg. No.	7 21451
	Physici /Medi		Decedent's Name (First, Middle, Last) Theodore		Edley		2. Date of Dea June 11	, 2007	Year 3. Time of Death 5:20pm M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of D	eath	4c. County of	of Death
			6000 Rosedale Drive		Hyattsvi				Georges
	Funeral Director		5. Social Security Number 5. Social Security Number 5. Sex 135 M 2 F 7. Age (In yrs. las	Yrs.) If Under 1 Year Months Days		Hrs. 8. Date of Birti Month, Day April	h, Year) 7,1925	9. Birthplace (State or Foreign Country) Washington D.C.
	land ow		10a. State 10b. County 10c. City, 1	Town or L	ocation				10d. Inside City Limits
	Man	to	Md. Prince Georges Hya	ttsv	ille				1∭ Yes 2 ☐ No
	or 28	Oirec	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
	ath w	ral	6000 Rosedale Drive		20782	.,,		U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be routified ut once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes, Sive Year or Dates:	13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	dispanic Originian, Mexican, Po Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. Black
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occup a kind of work done DO NOT use retired	nation during most of d)	working	16b. Kind of Bus	
	ed wil	Con	3yrs.	An	alyst			Governme	
Maryland	be fill ad oth even	To Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,		1)
ž	should and Men marke	L _O	McKinley Edley 19a. Informant's Name/Relationship (Type, Print)	10b Mail	ina Address (Street		sie Fortun Rural Route Numbe		State Zin Codel
<u>s</u>	nd 2 s lith an 27 is i						Hyattsvi	-	
Baltimore,	Pages 1 and nent of Health ant: If item 27 ury or other tu		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	e of Disp etery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - C	City or Town, State
Baltir	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	2		ss of Facility	5/07 Johnson & N.W. WDC		
8760,	The law requires that the death certificate be executed with the death certificate be executed with the attending physician and with the sage 2 should be detached for use as the burial-transit	dical Examiner	23a: Part1. Enter the disease, or comblications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First in shifting Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of the con	COluce of):	ter the mode of dyin		diac or respiratory ard	rest,	Approximate Interval Batween Onset and Death
.O. Box 6	at the death certific by the attending p lached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deati	ath 3	□Ectopic pregnancy □ Other (specify)	′		23d. Date Mont	of delivery th Day Year
Δ.	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting the Hypertensive Cardivascular Disc	ng in the u	Inderlying cause giv	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Vital Records,	The law requate has been page 2 shou	Completed	Diabetes Mellitus Type II				24a. Was a autop: perfor 1 ☐ Yes	sy pri med? de	ere autopsy findings available for to completion of cause of eath?
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				Death (Check only or		
Division of	Phys this ral dil	tlon: To	1 Yes 2 X No Hospital: 1 Inpatient 2 ER 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Outpatie b. Time o Injury	of 28c. Injur Work	y at	g Home 5 Resid 28d. Describe h	ence 6 Other ow injury occurre	
Divisi	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After this compietely filled in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, st	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai (29a. Certifier 1 Certifying Physician: To the best of my knowle (Check only one) 1 Medical Examiner: On the basis of examination and manner stated.	dge, deat and/or in	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
		ž	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)
	8,		ticem Col Higgs - Suprice	cus	D280	79		June 13	, 2007
	89		30. Name and address of person who completed cause of death (Item 23 Francine A. Higgs-Shipman, M.D.			Court S	te 200, La	argo Md.	20774
	Sta Registr		31. Date filed (Month Day Year) JUN 1 9 2007 June 32. Registrar's Signature	V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lillian Alma 2145 Evans 6 07 /Medical 4a. Facility Name (If not inefitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICS ENINSULA NEGIONRL MEDICAL ALISBURY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 221-18-7327 87 Director Pennsylvania 1/25/1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Innert of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural" or items 25a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Wicomico Salisbury 1 □XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21802 USA 213 A Davis St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Beacher Emma Jane Beacroft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5508 Morris Rd., Pittsville, MD 21850 Janie Goslee/daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Springhill Memory Department of Important: If it any injury or o once. 1 █ Burial 2 ☐ Cremation 3 ☐Removal from State 6/16/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 THE HAR ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician ear congestive disease or condition resulting in death) days /Medical Due to (or as consequence of) Examiner disease coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnous peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes eDX(No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

31. Date filed (Month, Day, Year) JUN 14 2007

Silvia

29b. Signature and title of certifier

(Check only one)

harles

Carroll 32. Registrar's Signature

24.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

,982

WG

29d. Date signed (Month, Day, Year)

3 O

DHMH 17 Rev 1/2001

ORIGINAL

			For 1 _ State	State of Ma	ryland	-			Mental Hy	giene	9		
	free!		Registrar 1. Decedent's Name (First, Middle, L	ast)	_	Cei	rtificate of	Death	2, Date of De	Reg. No	2011/	3. Time of Death	. 1
	Physici		Ann Marie Fil:						Month	Da	Year Year	1:16 A	VI
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of Death			. County of Death	- 	
	Funeral Director	£				st birthday) Yrs.	If Under 1 Year Months Days	agerstown If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	th ay, Year, 192	Washingt 9. Birth Cou	con County place (State or Foreig plorado	gn
	pug w		Usual Residence of Decedent 10a, State 10b, County		10c. Citv.	Town or Lo	cation					10d. Inside City Limit	s
	a-f sho	ctor		ington	,,		agerstow	n				X□Yes 2□N	
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 333 Mill Street	et			10f. Zip Code	21740		10g. Ci	tizen of What Cou	,	
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S o	i. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 🏖 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ameri Black, White Specify: Wh		
9500-6121	within 72 ho iene. than "natui the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+	+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire hild Psyc	during most of wor d)	king		and of Business/Ir	Practice	
yland z	ld be filed ental Hyg ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Las Charles J. Fi	et)			intra royo	18. Mother's Nan		, Maider			
, Mary	and 2 shou alth and M 27 Is mar er traumat		19a. Informant's Name/Relationship Michael D. Nee					and Number or Ru 51 Swanto				ip Code)	
ба ітіто ге,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		20b. Pla ce Sm	ithsb	osition (Name of matory or other pla urg Crema	atory 6-	Date 22–2007	Sm	_	Maryland	
balt	permit. Departimport any inj once.		21. Signature of Funeral Service Lice	ensee		1.	2. Name and Address 331 Easte	ess of Facility Dern Blvd.	ouglas <i>i</i> N. Hage	A. F	iery Fun own Mary	eral Home land 21742	2
ě	Dharainian		23a. Part1. Enter the disease or conshock, or heart failure. List onl	polications that caused by one cause on each line	the death.	Do not en	er the mode of dyi	ng, such as cardiac	or respiratory a	errest,		Approximate Interval Between Onset and Death	
N.	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	conseque	ence of):	luve					720	
je.	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	ence of):	e or ve					16	
28/60,	icate be executed physician and the burlal-transit	edical Exar	that initiated events resulting in death) Last	CDue to (or as a	conseque	ence of):							_
_	rtificat ng ph) as th	/ledi	IF FEMALE:										_
O. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burlal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 25No	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	□Ectopic pregnanc □ Other <i>(sp</i> ec <i>ify)</i> _	y			23d. Date of deliv Month	very Day Year	
cords, P.	uires that t signed by Id be detac	by	Part II. Other significant conditions	contributing to death bu	t not resul	ting in the u	nderlying cause giv	ven in Part I.			use contribute to	the cause of death?	vn
Hecol	e law has b je 2 sl	Completed		-						psy ormed2	prior to co	topsy findings availab ompletion of cause of	le f
VITal	ician: Th certificate rector, pag	a)	25. Was case referred to medical					26. Place of Dea	1 Yes ath (Check only	2 Ъ Д́ № оле)	o 1 □ Yes	2 □ No	
o -	di S	To B	examiner? 1 □ Yes 250 No	Hospital:		R/Outpatier	IL SELDOA		lome 5 ☐ Res	idence	6 □Other (Spec	rify)	
DUOIS	anding Physath. Pr: After this ne funeral di		27. Manner of Death 1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation			28b. Time o Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe	how inju	ary occurred		
DIVISION	tal or Attu s after de al Directo ed in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At hon . <i>(Specify)</i>	ne, farm, str	reet, factory, office	·	28f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	ral Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (Physician: To the best of aminer: On the basis of and manner state	examinati		vestigation, in my	opinion, death occu					
)	To the l within 2 To the l complet	Σ	29b. Signature and title of certifier	40			29c. Licens	2323 dagers		29d. Da	ate signed (Month	, Day, Year)	
54	-3		30 Name and address of person who Dr Waseew	1176	00	23a) (Type	ourt l	dagers	town	Ma	ryland		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 2	2007 32. Registra	r's Signati	ure	Inachis	•		<u></u>			
DHI	MH 17 Rev 1/2	001		James and and and and and and and and and and	-	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#27 per PHYS, C869, 7/2/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Dav Earl McKinley Green, Sr. 21 2007 3:15P June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westimms.

If Under 24 Hrs.
Months Days Hours Min.

Months Days Hours Min.

Month, Day, Year)

Feb. 25, 19 Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**⊠** M 2 □ F Director 83 217-12-2901 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 536 Green Valley Road 21791 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 farmer dairv is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John E. Green Mary Evea Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Annie O. Green/ wife 536 Green Valley Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ott once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. 6/25/2007 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home Wharene Union Bridge, MD 21791 6 E. Broadway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crevin Hommhorse **Physician** /Medical a consequence of): Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician as Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea n? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si 24a. Was an 2.4b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy perform certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) HSPICE Hospital: Other: 4 \sum Nursing Home 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determine 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certific 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 1/2001

5

State

3Q. Name and addre

Day,

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,2728a-f per me, 2869,07/02/07dhb

Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Day **Physician** 2007 2:50 P M May Chauncey M. Gilbert, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Heritage Harbour Health Center Annapolis 8. Date of Birth (Month, Day, Year) May 18, 1911 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours 1 XM 2□F Pennsylvania 95 227-20-4869 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notifiled Anne Arundel Crofton Directo MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21114 2539 Vineyard Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances M. Young Chauncey M. Gilbert ပ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a important: if item 27 is any injury or other trauonce. Crofton, MD. 21114 Ora N. Gilbert / daughter 2539 Vineyard Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 05/14/2007 Davidsonville, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Highway Bowie, MD. 20715 Ich 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Tona URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FRACTURS 24a. Was an autopsy page performe 2 No Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) Yes 200 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division or 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending investigation Accident 04/11/2007 Unknown M 1 🗌 Yes Subject fell filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2131 Davidsonville Road, Crofton, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Nursing Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADVATOUS MO 21701 2001 MEDICAL PARKISAY DOCGERS 5 MITCHEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 2 2007 Registrar

07-04487 John Milton Greenwood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ASP	Type of Fillit in Black indensite into	
400	1,100	
	State of Maryland / Department of Health and Mental	Hvalen
	State of Marviano / Departificit of Fleath and Montain	, 9.0

		- For State tegistrar		Certific	cate of i	Deam			To		g. No.	3. Time of Death
'hysicia	n/	 Decedent's Name (First, Midd) 	_{e,Last)} Milton Gre	enwood						Date of Death Month June 11, 20	Day Year	2146 hrs
Examir		4a. Facility Name (if not institution	on, give street and nu		41	b. City, Tov		ocation of	Death		4c. County of D	L L
		Prince George's Cour	nty Hospital			Chever				(P: I		. Birthplace (State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b		If Under Months	1 Year Days	If Under Hours	24Hrs. Min.		/1964	oreign Compress h., DC
Director	- 1	579-88-7885	1XM 2 F	43	Yrs.					01/22	,	
	Į	Usual Residence of Decedent 10a State 10b, County		10c. City, Tow	vn or Locatio	on						10d. Inside City Limits
w any	-	,	C				0.	xon I	1111			1 Yes 2 No
and sho	ō	Maryland Prin	ce George	S		10f. Zip C				10	ng. Citizen of What	Country?
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f show fraumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1602 Fenwo	od Avenue					0745			Unite	d States
th the 23a o		11, Marital Status		cedent Ever in U.S.	13. Was	s Decedent	of Hisp	anic Origi	n? (Spe	cify Yes or No	- 14. Race - / White, e	American Indian, Black,
ath wi	Funeral	1 Never Married 2	Married Armed F		If Ye	es, specify	Cuban,	Mexican,	Puerto F	(ican, etc.)	wille,	Sio.
er dez	리	3 Widowed 4 XD	1 Yes	ear		Yes 2					Specify:	Black
imore, MD 21215-0036 Pages 1 and 2 should be fifed within 72 hours after ment of Health and Mental Hygiest and matter first and 1s marked other than "matural", or other traumatic event, the Medical Examiner.	by	15. Decedent's Education (Sp			a. Deceden	t's Usual O ost of work	ccupation	on (Give k	ind of wo	ork done ed)	16b. Kind of Busin	ness/Industry
2 hou	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	during in	OST OF WORK	ing ino.	50		,		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medica	npl			1		Post	al_	Work	er	(=:	Gov Maiden Surname)	ernment
d will	Š	17. Father's Name (First, Middl	e, Last)				1	8.Mother				
ked o	Be	John	T. Greenw	ood					- 11 D	Juanita	Bullock	State, Zip (2009) 6
27 buld buld t I Mer s mar	ျ	19a. Informant's Name/Relation							, ,,			
MD 12 sh 12 sh th and th and th and th and th and th and		John T. Gr	eenwood/F	ather	ce of Dispos	4809 .	Penn e of cer	tiel neterv	d Ci	rcle,	Silver Sp	City or Town, State
Fiten		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Removal		matory or ot	ther place)		lem.				
Pages ent of nt: 1		4 Donation 5 Other		Hunt	sville	е Вар	t. (h		0/2007		
altir mit. 1 porta ury 0		21. Signature of Funeral Servi	ce Licensee	H	22.1	Name and			B.,		Funeral	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 permit. Pages I and 2 should be filed within 7 permit. If filen 27 is marked other than injury or other traumatic event, the <u>Medica</u>		Nohn I	Slewa	W. 11		the made o	4001	Ben	ning ardiac o	Rd.	NE Wash. rest, shock, or hea	DC 20019 Approximate Interval
ysician		23a. Part . Enter the disease, failure. List only one cau	or complications that se on each line.	t caused the death. D	o not enter	the mode c	n dynig,	30011 00 0		,		Between Onset and Death
/Medical		Immediate Cause (Final disea	se a Multiple l				_					
LAdminici	ı	or condition a sulting in death	Due to (or as	s a consequence of):								
	<u>ار</u>	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):								
	Ē	cause. Enter Underlying Cau (Disease or injury that initiate	d (.						_			
d d	Examiner	events resulting in death) Las	st Due to (or a	s a consequence of):								
1760, ficate be executed g physician and s the burial - transit			dAMENDE	D								
760, cate be exe physician he burial -	n/Medical	UNPENDED		es, outcome of pregna	ancv						23d. Date of	delivery
8760, tificate be ng physic as the burfast	1 5	IF FEMALE: 23b. Was decedent pregnant i		e birth		etal death	3	Ectop	ic pregn	ancy	Month	Day Year
, P.O. Box 687 res that the death certification signed by the attending.	sicial	past 12 months?	[]=	egnant at time of dea	th 5 (Other (Spe	cify)				ŀ	
BOy deatl	Phys	1 Yes 2 No 9		known	a diam in the	undorlyin	921127 7	given in F	Part I.	23e. Dio	tobacco use contr	ibute to the cause of death?
P.O. ss that the gned by	7		nditions contribution	ig to death but not res	Sulling in the	s dilucityini	goddoo	9.10		1 1	res 2 ✔ No 3	Probably 4 Unknown
ires the signe	2 5									24a. Wa	as an 24b.	Were autopsy findings available
rds v requi	Completed											prior to completion of cause of death?
ecol ne law nte has	7 28										s 2 No 1	Yes 2 No
Division of Vital Records, teal or Attending Physician: The law requirers after death. The After this certificate has been an all Director: After this certificate has been all the control of the contr	2 0	25. Was case referred to me						Other;		k only one)] n	Other:
Vita ysicia his ce	allec	examiner?	Hospital: 1	Inpatient 2			DOA	7		ing Home 5	Residence 6	
of Ving Physical After this	l nera	27 Manner of Death	28a. L	Date of Injury Month, Day Year) 11, 2007	28b. Time of 1800 hrs	of Injury		jury at Wo		Operator	of motorcycle	that collided with anto
on endir	the fu	Natural 5 1 2 Accident	Penaing							DOS Legation	n (Stroot and Numb	per or Rural Route Number, Cit
Visi or Att fter de Direct	in by	3 Suicide 6	Could not be 28e.	Place of Injury - At ho	ome, farm, st	treet, factor	ry, office	e building,	etc.	or Town	c Stata)	k Drive, Largo, Md.
Div	llled	4 Hamisida		cify) Local Stree								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending To the Fineral Director: After this certificate has been signed by the attending To the Fineral Director: After this certificate has been signed by the attending To the Fineral Director.			ng Physician: To the	e best of my knowledgesis of examination an	ge, death oc	curred at this	ne time, nv onini	date and on, death	place, ar occurred	nd due to the c d at the time, d	ause(s) and manne ate and place, and	due to the cause(s)
o the	omple	<u></u>	anu mam	asis of examination at ner stated.	noror myest			nse numb			29d. Date sig	ned (Month, Day, Year)
	- 1 -	29b. Signature and title of co						C.M.E.	J.		June 12, 2	
5		my	hi,					J. IVI. L.				
53)		30. Name and address of pe	erson who completed	cause of death (Item	23a)	root Rai	ltimore	MD 2	1201			
- 1				xaminer 141 2. Revistrar's 1994	rein St	icel, Da	annoi e	J, 1910 Z	, 20 ,			
	Sta	te 31 Presided (Pont) (14)	(ear) 3	2. Registrar's an late	u.e.							

		State of Ma		artment of Hertificate of L			1 1 1	mar nga		
	-	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No.	JI	2 Time of Dooth				
Physici	an				Year	3. Time of Death				
/Medi		Earl Roland Haley 4a. Facility Name (If not institution, give street and number)	June			9:28P "				
Examir	ner	Look About Manor		1						
Funeral			(In yrs. last birthday) If Under 1 Year	tminster If Under 24 Hrs.	8. Date of Birt	h		place (State or Foreign	
Director		Хти эпт	00 Yrs.	Months Days	Hours Min.	(Month, Da	8, 1907	Cour	ntry)	
D D		Usual Residence of Decedent					, , , , ,			
rylan how Lat		10a. State 10b. County	10c. City, Town or L	ocation				1		
e Ma Sa-f s	cto	Maryland Carroll		Westmin	ster				1 ∐Yes 2K No	
eros	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	
ath w 23a ust b	Funeral Director	1937 Old Taneytown Rd.			158					
er de tems	nue	11. Marital Status 12. Was Decedent Example Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rac Blac			
s affe	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	<i>'</i> :		
3-UU3G 72 hours at natural", or dical Exam		15. Decedent's Education	16a Dece	edent's Usual Occupa	ation		16h Kind of Bu	ame) Date of delivery Month Day Per a utopsy findings available prior au topsy findings available prior au topsy findings available prior au topsy findings available prior (Specify)		
in 72 in 72 in 76 ledic	Completed	(Specify only highest grade completed)	(Give	e kind of work done o DO NOT use retired	turing most of work	ing	Top. Tille of be	201110007111	duotry	
with jene	mo Du	Elementary/Secondary (0-12) College (1-4or 5+)	yardman			ra	ilro	ad	
Hyg Hyg other	Be C	17. Father's Name (First, Middle, Last)	'		18. Mother's Name	e (First, Middle,				
at y ital IQ Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hyglene. it marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To B	Louis Haley			Minnie	Minnie Mills				
shot and iv	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street a	and Number or Run	al Route Numbe	er, City or Town,	State, Zip	Code)	
e, Ivial 1 and 2 sl Health an Health an Hem 27 is r		Bettie J. Waldrup/ daughter	502	Uniontown	Rd.	Wes	tminster	, MD	21158	
item tem		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place	e)	Date	20c. Location -	City or To	own, State	
Pages nent of lint: If its		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			i	/2007	Finkshi	ıra.	мп	
DEMILITIONE, INIGITY IGHT A LAIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatule of Funeral Service Licensee	/ 2	22. Name and Addres	s of Facility Ha	tzler I	Funeral	Home		
		attarine Sarker		310 Church	St. No	ew Winds	sor, MD	2177	6	
		23a. Part . Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Interval Between	
Physician		Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Due to (or as a consequence of):								
/Medical		resulting in death) Due to (or as	consequence of):	1.000	2				rogians	
Examiner	,	Sequentially list conditions. b. COYOY		trany	Diseci	se			Oyears	
A D H	inei	cause. Enter Underlying	consequence of):					V		
that initiated events c.								_		
o / oU, cate be exchysician a	al E	550 10 (6) 20 2	consequence ory.							
physicate sthe	dical	d								
certif	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome p	fpregnancy				23d Dat	te of delive	erv	
DOX leath cer attendin for use	sician/Me	in the past 12 months? 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)					*	
the dy the ached	Physi	9 Unknown								
s that	by Pi	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to tl	ne cause of death?	
The Colds, F.O. BOX of The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	d be	Diabetes				1 🗆 🕆	Yes 2□ No	3 ☐ Prob	ably 4 Unknown	
aw re	plet					24a. Was		Were auto	psy findings available	
The I	Completed			·		autor perfo 1∐ Yes	rmed?	death?		
VII.di ician: T sertificat sector, pa	BeC	25. Was case referred to medical examiner?			26. Place of Deat					
nysic nis ce direc	ToE	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	ent 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Resid	dence 6 Seth	er (Specif	in Contraction	
Attending Physic death. rector: After this by the funeral of		27. Manner of Death 1 Natural 5 Pending (Month, Day	Year) 28b. Time	of 28c. Injury Work	/ at c?	28d. Describe I	now injury occur	red		
endingsth.	atic	2 ☐ Accident investigation		M 1	Yes 2 □ No					
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injur building, etc.	y - At home, farm, si <i>(Sp</i> ec <i>ify)</i>	treet, factory, office		28f. Location (3 City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,	
Hosp 24 hol Fune felly f	Medical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of 2 Medical Examiner: On the basis of end manner state	examination and/or i	ith occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as s and due t	tated. o the cause(s)	
thin (Mec	29b. Signature and title of certifier	-	29c. License	e number		29d. Date signe	d (Month.	Dav. Year)	
FSFS		Kan Dy 1. O Oak	MM)	Dar	55110	S	(0-	07 -	07	
		30. Name and address of person who completed cause of dea	oth (Item 23a) (Type	Print)	7777	O	V	^ /	<i>U</i>	
8		Kimbery A Johnston		omc Dr	we.11)07	·tre · m ·	tre m	0 2	1158	
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar	's Signature	200	,0000	, i i i i i i	1111	<u>, </u>	OF NO	
Registi	ar	JUL 0 3 2007 James	Si. Mil							

			For State	State of I	Maryland	•	rtment of H		Mental Hy	•	1 11 17	011.50
			Registrar 1. Decedent's Name (First, Middle, Li	ast)		061	incate of i	Death	2. Date of De	Reg. No.	6001	3. Time of Death
	Physicia		DOROTHY MAY	HAGER					Month JUNE	Day	200 ⁷	1:30P M
	/Medic Examin	Fall					4b. City, Town, or Location of Death			4c. County of Death		
	LXUIIII	•	FREDERICK MEMORIAL HOSPITAL				FREDERI	[CK		F1	REDERICK	
	Funeral		Social Security Number 6.		Age (In yrs. las		If Under 1 Year Months Days			rth ay, Year)	39 VA	place (State or Foreign ntry)
	Director		216-38-6247		67	Yrs.			Oct. 4	, 19	39 VA	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary -f sho fied a	to	MD Freder	lck	Fre	deric	k					1K∏Yes 2 No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	th wit 23a o 1st be		8501 Edgewood Cl	nurch Rd.			2170			U.S	.A.	
	r dea tems er mu	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D-	 Race - American Black, White, 	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	☐ Yes 2 No	Specify:			Specify: Wh:	ite
1215-0036	hour tural		15. Decedent's E			16a. Deced	ent's Usual Occup	ation			nd of Business/Ir	
ر ب	nin 72 n "na Medic	Completed	(Specify only highest g	rade completed) College (1-4	or 5+)	(Give life. [kind of work done OO NOT use retired	during most of w d)	orking			•
_	d with giene er tha th	mo.	Elementary/Secondary (0-12)	College (1-4	01 34)	Food	service	prep.		Foo	od	
פ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Las	t)					ame (First, Middle Wimmer	, Maiden	Surname)	
<u> X</u>		2	John Sheets		Т							
Maryland 2	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship				g Address (Street					p Code)
	1 and Health		Debbie McPhau1/ 20a. Method of Disposition	Daughter	20b. Pla	ce of Dispo	L'Flande sition (Name of natory or other plac	rs Lane	, Harwood		20776 ecation - City or T	own. State
no			1 Burial 2 Cremation 3 4 Donation 5 Dother (Spec				natory or other plac oln Cem.		15/07	Brei	ntwood,	MD
Baltimore,			21. Signature of Funeral Service Lice		100		. Name and Addre					
ñ	permit. Departi Importi any inj		I shrave a	h. Co	stilles		401 Blade	_	-		od, MD 2	0722
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final	1 1	the death.	Do not ente	to NCTI	ng, such as card	iac or respiratory	arrest,	Pisease	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	_ a.	as a conseque	nce of):	NO VICTI	v.C C	11110101	7 1	131426	
	Examiner		Sequentially list conditions, b.									
и.	pe tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	nce of):						
_	and A-tran	Examiner	that initiated events resulting in death) Last	nce of):								
8/60	cate be executed physician and the burial-transit	dical E		d								
89	ificate g phys	edic		- u.								
O. Box	at the death certificaby the attending platached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes		h 2 □ Fetal d nt at time of dea	leath 3□	Ectopic pregnancy Other <i>(specify)</i>	у			23d. Date of deliv Month	very Day Year
<u>ہ</u>	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to deat	th but not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
Vital Records,	w requires that been signed to should be deta	d by							_ 1_	Yes 2[□ No 3□ Pro	bably 4 Unknown
ပ္က	aw re	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
ř	The la	mo							- auto perf 1□ Yes	opsy formed?	death?	
Ta	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?						eath (Check only			
	Physic this ceral dire	To	1 ☐ Yes 202110	Hospital: Ling		R/Outpatien		4 🗆 Nursing	Home 5□Res			ify)
DIVISION OF	ding P h. After I funera		27. Manner of Death 1 Natural 5 Pending		Day Year)	28b. Time of Injury	Wor		28d. Describe	how injur	ry occurred	
Sic	or Attendatter death Director:	icat	2 Accident investigation 3 Suicide 6 Could not		finiury - At hom	ie, farm, str		Yes 2□No	28f Location	(Street an	nd Number or Bu	ral Route Number,
2	tal or Airs after or al Directed in by	Certification:	4 ☐ Homicide determine	d building	, etc. (Specify)	, ,	eet, factory, office			wn, State		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification by the funeral director, completely filled in by the funeral director,	Medical C		Physician: To the base aminer: On the base and manne	is of examination							
)	To th withir	Me	29b. Signature and title of certifier	=> 14)	>		29c. Licens	e number		11	te signed (Month	0'7
	Olan		30. Name and address of person wh	o completed cause			Print)		1 .		,	21702 * MD
	20		Hemen Shah	MD, 6	istrar's Signatu		nus job	mson	42)re	, F	vecleric	r MD
	Sta Regista		31. Date filed (Month, Day, Year) JUN 1 9 200/	32. Het	Jisuai S Signatu	KI						
D	MU 47 D 4/0	004		aren 10	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) une Thomas Sylvester Hawkins 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Lanham Doctor's Comunity Hospital 7. Age (In yrs_last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 9, 9. Birthplace (State or Foreign 5. Social Security Number Months Days Hours XXM 2□F Glenarden, Maryland 217-32-4383 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No Lanham Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 9115 Alcona Street 10f. Zip Code 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No if Yes, give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchants Terminal Warehouseman 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosie Ponger Albert Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9115 Alcona Street Lanham, Maryland 20706 Mrs. Ella E. Hawkins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ↑ Burial 2 Cremation 3 Removal from State Maryland National Mam. Park June 22, 2007 Laurel, Maryland 4 Donation 5 Other (Specify) Rollins Funeral Home, INc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sep1,5 unknow. Due to (ar as a consequence of): rostate Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

þ

Completed

Be

0

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Inipury or other than many Injury or other thaumatic event, the Medical Examiner must be notified at

Thomas Sylvester

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be (

Examine

1 Natural 2 Accident

Certification: To Medical

9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

29a. Certifier

3 ☐ Suicide 4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

29b. Signature and title of certifier Promote M. D

29c. License number

29d. Date signed (Month, Day, Year) 6.18.07

death?

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgea An suit 3-41 Silver pring FARAHIFAR

31. Date filed (Month, Day, Year) JUN 1 9 2007

32. Registrar's Signature

State

Physic /Medi Exami

Funeral Director

8.00	For	State of Ma		/ Depa	artment o	f Healt	th and M			-	4 - 7			
	1 - State Registrar			Cei	rtificate d	or Dea	ith		Reg. No	.4 U	11	6140		
an al	1. Decedent's Name (First, Middle, Last) JOHN HOMZA							2. Date of De Month June	Da	Day Year		3. Time of Death 3:06 a		
er	4a. Facility Name (If not institution, given	ve street and number)			4b. City, Tow	n, or Locat	tion of Death		40	. County o	f Death			
		Laurel Regional Hospital Laurel								Prince George's				
	5. Social Security Number 6. 3	e (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da 07-03-	ay, Year	7	Coui	place (State or Foreign ntry) nesota			
	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	ocation							Od. Inside City Limits		
tor		George's		nham								1 May Yes 2 □ No		
irec	10e. Street and Number		10f. Zip Cod	de			10g. Ci	tizen of W	hat Cour	ntry?				
<u></u>	7302 Finns Lane 20706 U.S.A.													
ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Decedent	of Hispanio	c Origin? (Sp	pecify Yes or No Rican, etc.)	D-			can Indian,		
F	1 ☐ Never Married 2 X Mamed	1 X Yes 2 ☐ I	No		1 ☐ Yes 2 🔀		ecify:	ornoun, etc.)			, White,			
by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			103 2Д	140 Ope	y.			Specify:	wn	Lte		
Be Completed by Funeral Director	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual Oo kind of work do DO NOT use re	cupation one during	most of wor	king		(ind of Bus		•		
npfe	Elementary/Secondary (0-12)	College (1-4or 5	5+)					5	Nav	_		ce Weapons		
Con		4		Mecha	anical						nte	<u> </u>		
Be (17. Father's Name (First, Middle, Las					18. M		e (First, Middle		n Surname	e)			
10	Michael Homz							a Dmyan:						
	19a. Informant's Name/Relationship							ral Route Numb				Code)		
	Doris E. Homza -	Wife	7-21-21				Lanha	am, Mary			706			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Pla	ce of Dispo netery, crei	osition (Name o matory or other	place)		Date		ocation - (
	4 ☐ Donation 5 ☐ Other (Speci		Fort	Linco	ln Cemete	ery	06-2	5-2007				Maryland		
	21. Signature of Funeral Service Lieu	nsee		Ga	2. Name and Adas ch's	dress of F Tuner	acility a1 Hon	ne, P.A.	739 'YHy:	Balt attsv	imor	e Avenue MD 2078		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death.	Do not ent	ter the mode of	dying, suc	h as cardiac	or respiratory a	ırrest,			Approximate		
	shock, or heart failure. List only Immediate Cause (Final	1/										Interval Between Onset and Death		
	disease or condition resulting in death)	Due to (or as			Infar	CLOII					-			
		,	•		Diagona									
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events													
ii.	cause. Enter Underlying Cause (Disease or injury													
Examiner	resulting in death) Last	c. Due to (or as	a conseque	nce of):				-						
cal		S.d.												
edic		-0.												
Ž	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome								23d. Date	of delive	ery		
ciai	in the past 12 months?	1 □Live birth 4□Pregnant at			⊒Ectopic pregn ⊒Other <i>(sp</i> ec <i>if</i>)					Mon	th			
Completed by Physician/Medi	9 Unknown	9□Unknown												
百	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the u	nderlying cause	given in F	Part I.	23e. Did	tobacco	use contri	bute to t	he cause of death?		
d b	Chronic Stage Four Kidney Disease 1□Yes 2☒No 3□Proba									pably 4 ☐ Unknown				
ete	Colon Cancer				·			24a. Was	an	24h W	lere auto	opsy findings available		
E C								auto				mpletion of cause of		
ပိ	Anemia	T						1□ Yes	2) N	0 1	□Yes	2 □ No		
Be	25. Was case referred to medical examiner?	Hospital:				Othor:		th (Check only						
ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a, Date of Inju	ent 2 EF	8b. Time o		4 L	☐ Nursing H	ome 5 Resi				(y)		
io	1 Natural 5 ☐ Pending	(Month, Da		Injury		njury at Work? 1 □ Yes	2 □ No	Zod. Describe	now mje	ily occurre	·u			
cat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e Place of init	ury - At hom	e farm etr			2 🗆 140	29f Location /	Stroot a	nd Numbo	ror Pum	al Route Number,		
ŧ	4 ☐ Homicide determined	building, et	c. (Specify)	0, 141111, 50	cot, lactory, on			City or To			i or riare	ar rioute runnoer,		
ŏ	29a. Certifier 1 ☑ Certifying P	hysician: To the best	of my knowl	edne deat	h occurred at th	e time da	te and place	and due to the	causel	and mai	nor as s	tated		
Medical Certification:		miner: On the basis of and manner sta	f examinatio											
Me	29b. Signature and title of certifier	11/1			29c. Lic	ense numl	ber					Day, Year)		
	· CVL C	/ /		N	D I	00064	986		6	118,	120	07		
	30. Name and address of person who	completed cause of d	eath (Item 2	(3a) (Tyne	Print)									
	Chike Onwuka, MD,	10724 Lit	tle Pa	tuxer	it Parky	vay,	#200,	Columbi	ia, 1	Mary1	and	21044		

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2007

17

State Registrar 2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar		Cei	rtificate of i	Death	
Physician /Medical	1. Decedent's Name (First, Mic Pearline Ha	,	son			2. Da M
Examiner	4a. Facility Name (If not institu	tion, give street and n	umber)	4b. City, Town, or	Location of Death	
	Southern Ma	ryland Hos	spital	Clin	ton	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Da

Reg. No. 3. Time of Death

ate of Death Day onth 10:50A.M une 15, 2007 4c. County of Death Prince George's Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2X F 79 579-38-2508 1/27/28 Eastman, Ga Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Md. P.G. Oxon Hill 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 Leland Drive 20745 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ♣★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Black Specify: Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 3 Years College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Harvard Sallie Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pamela H. Dickerson/Daughter

1499 Ft. Davis St., S.E., Washington, D.C. 20020

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify)

20c. Location - City or Town, State 6/22/07 Suitland, Maryland

21. Signature of Funeral Service Licenses

22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019

23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): HYPERTENSIVE CARDISVASCULAR Due to (or as a consequence of)

CARDICVASCOLAR CELLARSE

Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☑ No

IF FEMALE:

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery Month Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

PULMONARY

1 Yes 2 No 3 Probably 4 Nonknown

23e. Did tobacco use contribute to the cause of death?

autopsy performed

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death

1⁴ Natural

29a. Certifier

2 Accident

(Check only

28a. Date of Injury 5 ☐ Pending investigation

1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 28b. Time of (Month, Day Year)

28c. Injury at Work?

1 ∏Yes 2 ∏No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number P050

29d. Date signed (Month, Dav. Year) 6-15-2007

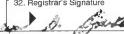
30. Name and address of person who completed cause death (Item 23a) (Type, Print) VICTOR E. HERRY, AD. CM

MARYLAND

PISCATAWAY 31 31. Date filed (Month, Day, Year)

CLINTON Ra 32. Registrar's Signature

JUN 2 0 2007



Registrar DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death winnent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a ury or other traumatic event, the Medical Examiner must b Maryland 21215-0036 Saltimore, permit. Page:
Department o.
Important; If i
any Injury or **Physician** Examiner

/Medical

use as the burial-tran

for

pe

attending physician

Director

r 28a-f show notified at

a or

Director

Funeral

Completed by

Be

၀

Examiner

Physician/Medical

δ

Completed

Be

Certification: To

Medical

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ed by or Attending Physician: the Hospital

page 2 certificate this funeral After within 24 hours after death To the Funeral Director: the filled in by

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Earl Hammons 18 2007 04:50 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurelwood Nursing Home E1kton Cecil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1**X** M 2□ F 415-18-9472 86 March 16,1921 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Completed by Funeral Director Maryland | Ceci1 Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Greenway Apt. 104 21903 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Affiled Folces. 1 □XYes 2 □ No If Yes, Give Year or Dates:1939-45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 27 No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Set-Up Man Steel Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Charles H. Hammons Julie Richmond ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6449 Rella Circle, Unit 105, Roynton Beach, Florida ace of Disposition (Name of Date 20c. Location - City or Town, State William Freeman / Stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 3 ☐Removal from State 1 XBurial 2 ☐ Cremation Highview Memorial Park 21, 2007 |Fallston, Maryland 4 □ Donation 5 ② Other (Specify) 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final years disease or condition resulting in death) Palmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) vsician/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

Physician

/Medical

Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year					
Part Ii. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	cause given in Part I.		use contribute to the cause of death?		
				24a. Was an autopsy performed? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3 □ De	Othor	eath (Check only one) Home 5 Residence	6 ☐Other (Specify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factor	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	nysician: To the best of my knowniner: On the basis of examination				e) end manner as stated. Id place, and due to the cause(s)		

29c. License number

10023322

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title Certifier

31. Date filed (Month

Lachders no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEV MD 118 North St Stute 3B, Elector MD 2192

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE Physician 2007 16 5:48 PM Isolde Herron Klara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 □ M 2 🛛 F 74 1933 Germany Director 575-60-4217 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Director Waldorf Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 5400 Lucy Drive USA is 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23 other traumatic event, the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married White HERRON KIARA Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) Anna Heinickel Hermann Erich Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5400 Lucy Drive, Waldorf, MD 20601 Harold D. Herron - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery 6-25-2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M1246 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence P.O. Box 68760, Physician/Medical as tate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contribying to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 X No or Attending Physician: 25. Was case referred to me examiner? 26. Place of Death Check onl one funeral director, Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OMAIS CENNA MEDICAL CENTER 7-C POST OFFICE RD. WALDORF MD. 20602 ABBAS

31. Date filed (Month, Day, Year)

29b. Signature ar

JUN 19 2007

of certifier

goods

State

Registrar

D- 57708

29d. Date signed (Month, Day, Year)

7. Age (In yrs. last birthday)

75

10c. City, Town or Location

Rockville

Hirsch

1 □ M 🛣 F

Shady Grove Adventist Hospital

Montgomery

1801 E. Jefferson Street, # 306

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

098-24-3361

10a, State

Maryland

11 Marital Status

10e. Street and Number

Director

Usual Residence of Decedent

Muriel

4a. Facilify Name (If not institution, give street and number)

10b. County

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

20852

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Rockville

Days

10f. Zip Code

Day

16,

10:43 P^M

1∰ Yes 2 No

Year

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an item into yor other traumatic event, the Medical Examiner must be notified at once.

Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ğ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Lisual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher-Public Schools 17. Father's Name (First, Middle, Last) Leon Marcus Rose P 19a. Informant's Name/Relationship (Type. Print) Douglas K. Hirsch - Son 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Beth David Cemetery 6/19/2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physician and for use as the burial-transit Bowl Ischemia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐**X**No detached the 9□Unknown 9 D Unknown been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Be Completed page 2 1□ Yes or Attending Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 🛣 No 2 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 1/0064560

8. Date of Birth (Month, Day, Year)
Aug. 27, 1931 9. Birthplace (State or Foreign New York 10d. Inside City Limits

Year

2007

Montgomery

4c. County of Death

10g. Citizen of What Country? U. S. A.

Black, White, etc. White Specify:

14. Race - American Indian.

Education

18. Mother's Name (First, Middle, Maiden Surname)

Month

June

(Unascertainable)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10823 Pebble Brook Lane, Potomac, Md. 20854

20c. Location - City or Town, State

Elmont L. I., New York

DANZANSKY-GÖLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Approximate Interval Between Onset and Death **Days**

Days

Days

23d. Date of delivery Month

Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Winknown

> 24b. Were autopsy findings available prior to completion of cause of death?
>
> 1 ☐ Yes 2 No 24a Was an

2 XNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 18, 2007

30. Name and addies of person who completed cause of death (Item 23a) (Type, Print)
Nidhi Singn Nikmns, M. D. 9901 Medical Center Drive, Rockville, Maryland 20850 Nidhi'Singn Nikmns, M. D.

State Registrar



State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 11:23PM M Priscilla Edna Hoffman June 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4342 Waddells Corner Road Hurlock Dorchester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 21,1919 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 213-12-5971 88 Director Maryland Usual Residence of Decedent 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits I Hygiene. . other than "natural", or Itame 23e or servivent, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4342 Waddells Corner Road 21643 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Š Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygies Important: if Itam 27 is marked other tt any injury or other traumatic avent, III.a. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Thomas Bertie Scott 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Truitt/Daughter 6530 Eldorado Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation _5 ☐ Other (Specify) East New Market Cem. 6/19/2007 East New Market, MD Zeller Funeral Home, P. O. Box 207 106 MainStreet, East New Market, MD 21631 21. Signature X Frineral Service Qce 7 ee Danie 29a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary 4Par /Medical Due to (or as a consequence of): **Examiner** congestive month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed anding physicien and use as the burial-translt pertension lear: Due to for as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 💢 No Sid. : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury death. i Director: A 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge, MD Bramble 31. Date filed (Month, Day, Year). State Registrar

Saltimore, Maryland 21215-0036

burial-trar

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 11:40P M Shurly Russell Irish III 2007 June 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9524 Briar Glenn Way Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 10**X**M 2□ F Hours 329-40-7583 60 Director Dec. 22,1946 WI Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: If Item 27 is marked other than "netural", or Items 23a or 28a-f show yor or other traumatic event, the Me "it al Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9524 Briar Glenn Way 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decedents Susual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
nior Assistant for Audit
Operations College (1-4or 5+) 5+ Elementary/Secondary (0-12) Senior Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shurly Russell Irish Jr. Ruth Marie Ritsch ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20886 Karen Janice Irish / Wife 9524 Briar Glenn Way, Montgomery Village, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Importent: If I eny injury or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State June 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 IRACU Twe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Small Cell Lung Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a the burial Physician/Medical attending phy d for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral 29a. Certifier [XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42452 heide June 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D., 1811 Prince Philip Drive #327 , Olney , MD 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 19 Registrar JUN

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 30-2 PM Physician 5 2007 ONE Bertha Katherine Jackson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🖸 F 217-32-7620 1936 Maryland 71 Feb. 8, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show say injury or other trsumatic event, the Macical Experiment be notified at once. 1 X Yes 2 No Cecil Perryville Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21903 U.S.A. 6 McGuire Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Maryland 21215-0036 White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker Seven Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frances Estelle Button Oliver Washington Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine E. Shelley (Daughter) 3717 Level Village Road, Havre de Grace, MD 21078 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 06/18/07 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Sign were of Funeral Service Licensee Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. anoxic encephalopathy Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): proctory **Examiner** res if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months
1 Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o. 9☐ Unknown 9 ☐ Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier June 15 2007 H55222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hove De Grace MS 21078 S. UNION and 501 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

			_ For	State of Marylar	•			d Me	ntal Hyg	iene.		311.50
			1 - State Registrar		Cer	tificate	of Death			g. No.	3 1	1-1-1-2
T	Physici	an.	1. Decedent's Name (First, Middle, La.	" II TI	. 1.	_	Tours	2	. Date of Deat _Month	h <u>Da</u> y	Yeer	3. Time of Death
	/Medic		rvonne v	alley 11	noma	12	Juyne	> [luve	111	300/	6.95 M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		- 1	own, or Ubcation of D	eath			(Om	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	- Constitution of the Cons	If Under 1	Year If Under 24	vin.	Date of Birth (Month, Day,	Year)	9. Birth	nplace (State or Foreign
Н	Director		Usuet Residence of Decedent	1	Yrs.			n	IAR. 23	,1932	200	th (arolino
	land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	a-f sh	tor	Md Wice	omico S	Salis	, bu	24					1 ☐ Yes 2 X No
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Trarked other than "natural", or items 23a or 28a-f show marked other than "natural", printernal be notified at matter a want, the Madical Extension.	Funeral Director	10e. Street and Number	JK C+		10f. Zip C	ode		1	0g. Citizen d	of What Col	untry?
	eath v	erai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decede	nt of Hispanic Origin	? (Specif	y Yes or No-			ncan Indian,
٥	or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		fYes, specif □ Yes 2	Y Cuban, Mexican, P No Specify:	uerto Rio	can, etc.)	Spec	llack, White	e, etc.
215-0036	filed within 72 hours after Hygiene. other than "natural, or ite ant, the Medical Extinition	d by	3 Widowed 4 □ Divorced	Year or Dates:	16a. Deced					16b. Kind of	1)	nductor.
7	n nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed) Coltege (1-4or 5+)	(Give	kind of work OO NOT use	done during most of retired)	working		Sho	Y P	Up 1
717	d with giene er tha	Com	Elementary/Secondary (0-12)	College (1-401 34)	Medi	cal T	rans pur			97.0		٠,
and	be file ital Hy d oth svsnt,	Be (17. Father's Name (First, Middle, Last)	1			18. Mother's	Name (/	First, Middle, I	Maiden Sum	ame)	
	should be nd Mental marked o	T ₀	Jessie E.	Thomas	T		Lau	NCL		HAL	ال	
Mary	2 2 3		19a. Informant's Name/Relationship	Type, Print) VINS (daughter	19b. Mailin	01 1	oretho k	r Rural F	D .	0	m, State, Z	1 21853
	Health Health tsm 27 other ti		20a. Method of Disposition	20b.	Place of Dispos	sition (Name	of	Dat	1 rince	20c. Locatio	n - City or	Town, State
ē	Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	nue we	sley (emetery	6/1	0/07	Mari	OKIN	, Md
Baltimore,	artin artin		21. Signature of Euneral Service Licer		22	. Name and	Address of Facility		917 W	ISA		St
<u>n</u>	Per in Per		M	sett)		+ UM	Seven Hor	re.		ilisb	JRH	md 2180
			23a. Part1. Enter the disease, or com- shock, or hear failure. List only	one cause on each line.		_		diac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mefast		Lung	Cance					19000
	Examiner			Due to (or as a consec	querice or).							
	© # = 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	cate be executed chysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	nuence of):							
8760,	be ex	dicai E		4	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
28	ificate g phy: as the	edic		0.								
XOR	eath certific attending p i for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Ectopic pre	nancy				Date of deli	very Day Year
Э. П	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o	death 5	Other (spe	city)	-			VIOLILI	Day Toda
7	that the	/ Ph	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the ur	nderlying car	ise given in Part I.		23e. Did tol	acco use co	ontribute to	the cause of death?
ecoras,	w requires that been signed b should be deta	ed by						_	12 XY	s 2 🗆 No	3 🗆 Pro	obably 4 Unknown
ဝ ဝ	law reas bee	Completed							24a. Was a			topsy findings available completion of cause of
r		Com							perform	ned?	death? 1 ☐ Yes	2 No
Vital	ician: Thy certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		Check only on			
0	Physic this ral dir	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of		4 🗆 1901511		5 Reside			cify)
o	ding th. : After s fune	tion	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	м	c. Injury at Work? 1 Yes 2 No			,,		
DIVISION	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, stre	et, factory,	office	28	Location (SI City or Town	reet and Nu	mber or Ru	ral Route Number,
5	oital or urs aft ral Di											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filted in by the funeral director,	Medical		ysician: To the best of my knowner: On the basis of examinating and manner stated.								
	o the	Me	29b. Signature and title of certifier			29c.	License number		2	9d. Date sig	ned (Month	n, Day, Year)
	/		10/	- m. s	, .	2	73069	U		70~	15	2007
(DADY		30. Name and address of person who	completed cause of death (Ite-	m 23a) (Type, I	Print)						
	. 00		Jones E. MA.2			. Cer	11 77.	, >	e. 1 ; 5 6	1		"",
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	S Section and						

			1 - For State Registrar	State	of Marylar		artmer rtificat					giene Reg. No.	200	7 21470	
	Dhyoisi		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath Day	Yea	3. Time of Death	
а	Physicia /Medic		Ke	nneth Kel	L1y						June	10	200	1.4	
	Examin		4a. Facility Name (If not institution	give street and n	umber)		4b. City,	Town, or	Location of	of Death		4c.	County of De	ath	
			12003 North		Ave.				er Ma		oro]	Prince	George's	_
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.	V	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	y, Year)		irthplace (State or Foreign Country)	
	Director		579-56-2576	72	65	Yrs.					Dec. 1	9, 19	941	Wash., DC	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Mary f sho	٥.	6 1 1 D	0			,	т.	16					1 XYes 2 No	
	28e	Director	Maryland Princ 10e. Street and Number	e George	S		10f. Zig		_Mar	Lboro		10a. Citiz	zen of What	Country?	-
	3a or		12003 North	Marlton	Ave.				207	772		-		States	
	death	Funerai	11. Marital Status	12. Was De	edent Ever in U	l.S. 13.	Was Dece	dent of Hi			ecify Yes or No Rican, etc.)		14. Race · Ar	nerican Indian,	-
٥	after or its		1 Never Married 2 Marri	Armed F ed 1 □X/es	2 No						Hican, etc.)		Black, WI		
2	ours iraf,	d by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:		1□ Yes	ZKI NO	Specify:				Specify:	Black	
9500-5121	filed within 72 hours after death with the Maryland Hygiene. Hydiene. Inter then "natural", or iteme 23a or 28e-f show ent, the Madical Examinar must be notified at	Completed	15. Decedent (Specify only highes)	16a. Dece	kind of wo	rk done d	urina mos	t of worki	ng	16b. Kir	nd of Busine:	ss/industry	
2	of thin	m	Elementary/Secondary (0-12)	· ·	(1-4or 5+)	life.	DO NOT u								
N	e filed v I Hygie other t	ပိ	17. Father's Name (First, Middle,	4			Car	togr	apher		(First, Middle,	Maidan		rnment	_
Ē	od of other	Be							16. MOLITE	or S Maille	Berni				
ج	hould d Me d Me mark matic	ဥ	Robert 19a. Informant's Name/Relations			10h Mailie	aa Addros	(Stroot o	and Alumba	or or Pura	Deriii			Zin Codol	_
Maryland 2	d 2 s th an 7 is r traur		Bernadette K		.		_				Upper			· ·	
	ages 1 end 2 should be fi nt of Heelth and Mentel H :: If item 27 is marked ott y or other traumatic ever		20a. Method of Disposition	011) / 1111	20b. F	Place of Dispo	sition (Na.	me of	1		ate			or Town, State	_
Baltimore,	Pages nent of int: If it iny or o		1 XBurial 2 ☐ Cremation		State (cemetery, crei	matory or o	other place	´ I				82.7 10		
Ξ	permit. Page Dapartment of important: If eny injury or once.		4 □ Donation 5 □ Other (S _I 21. Signature of Funeral Service)		Mar		Veter 2. Name a				/2007 _ Stewart		elteni	ham, MO	-
n n	Dape imp			Stew	atti									C 20019	
			23a. Part1. Enter the disease, or	70.00		th. Do not ent							J. 1. , D		
	Nevatata.		shock, or heart failure. List Immediate Cluse (Final	only one cause on	each line.				,					Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		fultiple (or as a consec		ma							6 Months	_
	Examiner			Due to	(OI as a COIISEC	(uence or):									
		Je.	Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury	b. Une to	(or as a consec	queries of):								1	Ť
	cuted ransit	Examiner	Cause (Disease or injury that initiated events	,											
o,	en ar en ar irial-t		resulting in death) Last	Due to	(or as a consec	quence of):						-			
3/60	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be deteched for use as the burial-transit	Physician/Medical		d							·				
õ	ntifica ing pt	Med	IF FEMALE:					-				- 1			
X P P	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, o 1 ☐ Live	utcome of pregnation of birth 2 Feta		Ectopic p	regnancy				2	3d. Date of	•	
3	e des the at	sici	1 Yes 2 No	4□Preg 9□Unk	nant at time of o	death 5	Other (s	pecify)					Month	Day Year	
л Э	res that the de signed by the a be deteched f	F.		na acataibutian ta	daath but ast seen		. 4 . 4				On- Dida				
Š	ires ti signe	Ď	Part II. Other significant condition	ns contributing to	dealin but not res	suiting in the u	naertying t	ause give	in in Parti	•	1	Yes 2	7	to the cause of death? Probably 4 □Unknown	
Vital Records,	w require been si should ?	Completed				·						- 20	3140 30	Flobably 4 Olikhowii	
် စိ	The law cate hes t page 2 s	ig									24a. Was autor	osy	24b. Were prior t	autopsy findings available o completion of cause of	
<u>_</u>	cate h										1 ☐ Yes	rmed? 2 🖾 No	death 1 🗌 Y	f es 2□No	
Ž	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				1.00		of Death	Check only o	ne)			_
0	Phys this aldi	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1		ER/Outpatier			4 140		me 5 Resid			pecify)	
	ding I	Ö	1 ☑Natural 5 ☐ Pendin		of Injury oth, Day Year)	28b. Time o Injury	м	28c. Injury Work	at ? /es 2 □		28d. Describe l	now injury	occurred		
DIVISION	Attending ir death. ector: After by the fune	lica	2 Accident Investig	ot be	e of Injury - At h	ome farm st			93 2		28f Location (Street an	d Number or	Rural Route Number,	
5	eftar Dire	Certification:	4 Homicide determ	ned build	ling, etc. (Speci	fy)	eet, lacioi	y, once		1	City or Tov	vn, State,)	nurai noure ivumber,	
_	To the Hospital or Attenwitin 24 hours eltar deal To the Funeral Director: completaly filled in by the		29a Certifier 1 Certifyin	g Physician: To It	e best of my kno	wiedoe deel	h occument	at the nin	e. data an	id place:	and dualin the	caunatel	and warner	as status)	
	• Ho 24 h • Fui letaly	edicai	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation	, in my of	inion, dea	th occurr	ed at the time,	date and	place, and d	ue to the cause(s)	
	To the within 2 To the complei	Me	29b. Signature and title of certifier	1	,r	Dir.	29	c. License	number			29d. Dat	e signed (Ma	onth, Day, Year)	
	IDI		> ond	my 1	mo t	PHYSIC	IAN.		D5359	90			lune 1	3, 2007	
	181		30. Name and ad less of person	who completed car	se of death (Iter	m 23a) (Type,	Print)			, 0			une 1	3, 2007	
	j		Sydney D				,	#609	, Bal	timo	re, MD	212	205		
	Sta		31 Date filed (Moarb Cay Year)		Registrar's Sign										
*	Registr	ar	JUN T A COOL	Teren 1	- ppe										

Kenner John Henry Baltimore Maryland 21215-0036

		T = For State Registrar 1. Decedent's Name (First, Middle, La	State of Maryland		rtificate of			eg. No. 2 0 0 7	3. Time of Death
Physi /Med		John H. Ken	-				JUNE	Day 11 200	7 10:14 PM
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death Lanham		4c. County of Dea	George's
**************************************		Doctors Hospit 5. Social Security Number 6.5		t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
Funera Directo			1 □ MM 2 □ F 86	Yrs.	Months Days	Hours Min.	Aug. 26	, 1920 Sou	th Carolina
Maryland -f show fied at	tor	10a. State 10b. County Maryland Prince	George's	Town or Lo	ocation	Mitchel:	lville		10d. Inside City Limits 1 AYes 2 No
h the	Director	10e. Street and Number	000280		10f. Zip Code		10	0g. Citizen of What Co	
23a c ust be						20721		United	
s 1 and 2 should be filed within 72 hours after death with the Maryland 1 and 2 should be filed within 72 hours after death with the Maryland 1 the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
in 72 hour	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work		16b. Kind of Business	/Industry
d withir giene. er than the Me		Elementary/Secondary (0-12)	College (1-4or 5+) 4		Past			Govern	ment
d be filed ental Hyg ced othe c event,	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam			
ould b Ment arkec	100	John Henry						Kenner	7:- 0-4-1
d 2 shoth and th and 17 is mutaum		19a. Informant's Name/Relationship			-			; City or Town, State,	
iges 1 and 2 nt of Health a if Item 27 is or other tra		Sharon L. Kels 20a. Method of Disposition	20h Pla	ce of Disp	osition (Name of	i	Upper Ma	r1boro, MI 20c. Location - City of	Town, State
mit. Pages partment of h		1 ▼Burial 2 □Cremation 3 I	_Removal from State	netery, cre Linco	matory or other pla	се) ery 6/19	/2007	Brentwoo	d, MD
+ セゼラ	انه	21. Signature of Funeral Service Lice			2. Name and Addre	ess of Facility	Stewart	Funeral Ho	
Dep and and and and and and and and and and	ouce	1 Phon T.	Steresart III		4001	Benning R	d., NE	Wash., DC	20019
Physicia		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Caus (Final	a. Due to (or as a conseque b. Due to (or as a conseque c.	Do not er	iter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	a. Due to (or as a conseque	nce of):		0,0,0		·	-
Examine	er	Securational list conditions	b. Type	II	25 0/0	setes	nell	i tus	
p pis	i de	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of).	1015	300			
be executed clan and burial-transit	Fyaminer	that initiated events resulting in death) Last	Due to for as a conseque	ince of):					
ificate be ex g physician as the burial			d. Hypo	1+~	100,01	ism			
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Dhveician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3	□Ectopic pregnanc □ Other (specify) _	cy		23d. Date of do Month	elivery Day Year
uires that signed b					underlying cause gi	ven in Part I.			to the cause of death? Probably 4 □Unknown
law req	atal	Senera	Annang				24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
The The page	Completed by		end Failu	عہ			autops perfor 1□ Yes	med? death? 2万No 1 □Ye	
Physician: r this certific ral director,	a	examiner?	Hospital: 1 ☑ Inpatient 2 ☐ E	B/Outpatie	ent 3 DOA Ot	hor:	th Check onl on	ne ence 6 ⊟Other <i>(Sp</i>	anifed
Phys er this eral dir	F		28a. Date of Injury	28b. Time				ow injury occurred	ecny)
nding th. r: Afte	1.2	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year) on	Injury		Yes 2 No			
I or Attending after death. I Director: Afte	Cortification.	3 Suicide 6 Could not 4 Homicide determine		ne, farm, s	treet, factory, office		28f. Location (S City or Town	treet and Number or I n, State)	Rural Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Modical		Physician: To the best of my know aminer: On the basis of examination and manner stated.	rledge, dea on and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, c	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To th within To th	M	29b. Signature and title of certifier	01100			se number		29d. Date signed (Mo	
50		> m. 2 her		2201/70	D O	36650	1	June 12,	100+
y		30. Name and address of person who Mulcenil Abo	o completed cause of death (Item (1997))	undo	verRd.	Suito ?	3, Che	verly, n	1D. 20785
	State	31. Date filed (Month 2007 (ear)	32. Recestrar's Saries		,		t) '	
ricg	isti a	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 7:39 PM **Physician** 2007 Theodore Andrew Kalkbrenner UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington County Hospital Hagerstown Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F 47 05/22/1960 198-56-8010 PA Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. **is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No MD Washington Hagerstown Director 10f. Zip Code 21740 10g. Citizen of What Country? 10e. Street and Number US 9608 Wandering Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Pest Control Operations Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Ann Lucas Frederick (unk) Kalkbrenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9608 Wandering Lane, Hagerstown, MD 21740 Cindy S. Kalkbrenner / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory 06/23/2007 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensus 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) feral neumone & **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-trar Due to (or as a consequence of) attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 TYes Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4BE985 24a. Was an certificate has autopsy performed page Caronar 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 Impatient 2 ☐ ER/Outpatient 3□ D0A Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of tath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Littural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: Hospital or Attending thours after death.

-uneral Director: Afely filled in by the fur e Funeral completely

95H-10

within 2

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

OSpitalist

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

		-	For State of Maryland / Department of the State of For State of Maryland / Department of the State of Maryland / Department of Maryland / Department	rtificate of Death	Reg. N	A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
e.	Physicia	an	1. Decedent's Name (First, Middle, Last)	2		3. Time of Death
	/Medic	al	Kenneth Earl King 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	IUNE 1	8 2007 10:05 PM
j.	Examin	er	Washington County Hospital	Hagerstown		Washington County
100	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Sex 124-48-9906 124 61 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea July 23 1	
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lit	ocation		10d. Inside City Limits
	e Maryla 8a-f shov tified at	ctor	102.000.0	agerstown		1 □Yes X □No
	th with th 23a or 28 ist be no	Funeral Director	10e. Street and Number 118 Southern Oak Drive	10f. Zip Code 21740	10g. C	Citizen of What Country? U.S.A.
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
7-0-7	hin 72 ho e. an "natu l Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	7	Kind of Business/Industry
7	ad wit	Con	11	Dairy Farmer 18. Mother's Name (Self Employed
<u> </u>	t be fill antal H ed oth	Be	17. Father's Name (<i>First, Middle, Last)</i> Earl Virginia King	, i		es Brown King
2	should nd Me mark mark	은		ing Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip Code)
, Mc	and 2 salth a n 27 Is er trau			Southern Oak Drive		
more	Pages 1		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	osition (Name of matory or other place) wn Cemetery June 2	I	Location - City or Town, State ig Pool Maryland
Ballimor	permit. Departm Importa any inju			2. Name and Address of Facility Dou 331 Eastern Blvd. N		
j.	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
08/00,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate adults. List underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
O. Box 6	death certif s attending d for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	requires that the een signed by the nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☑ 1√10 3 ☐ Probably 4 ☐ Unknown
VIТАІ Несога	The lar ate has page 2	Completed			24a. Was an autopsy performed'	
VII	lysiclan: is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		0 □0/h (0/4-)
on or	ding Ph J. After th funeral	tion: To	1 Yes 2 No rospital. 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident Properties. 1 Properties. 1 Properties. 2 Sa. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28	8d. Describe how in	e 6 □Other (Specify) njury occurred
DIVISION	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the properties of examination and/or and manner stated.			
	To the within 2 To the complex	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Muchael y. Milorail Me	0 41667		6.19.07
1	H-12		30. Name and address of person who completed cause of death (Item 23a) (Type Michael McCormack 1/1/0	Medical (to.	was la	Resolven MD
		ate rar	29b. Signature and title of certifier Michael Mulconaul Me 30. Name and address of person who completed cause of death (Item 23a) (Type Michael Melorack 1110 31. Date filed (Month, Day, Year) JUN 2 0 2007 32. Registrar's Signature June 1	Sperke	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT KEMELHOR P^{M} JUNE 15, 2007 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3701 INTERNATIONAL DRIVE APT 338 MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 11₹ M 2 □ F 95 Yrs. 084-03-1967 NEW YORK, NY **Director** AUG 11, 1911 Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County MARYLAND MONTGOMERY SILVER SPRING Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n with 1 3701 INTERNATIONAL DRIVE APT 338 20906 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAX KEMELHOR MARY ROSEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY KEMELHOR/WIFE $^{3701}_{20906}$ INTERNATIONAL DRIVE, APT 338, SILVER SPRING, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3X Removal from State NATIONAL CREMATORIUM | 06/21/2007 | FALLS CHURCH, VIRGINIA 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Furnitud Service Licensee 22. Name and Address of Facility
ANZANSKY—GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER LESS THAN 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician ar the burial-t Due to (or as a consequence of) Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy s certificate has lirector, page 2 performed' 1 Yes 2 XNo director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ို 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical

State

Registrar

21215-0036

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) JUN 1 9 2007

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature CERLACI

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. PAUL PANNEN, ISIII PRINCE PHILIP DRIVE #327, OLNEY, MARYLAND

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD060335

29d. Date signed (Month, Day, Year)

20832

JUNE 17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25, 2007 6126A Erma UNC. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 110ms) enta 30121 Westminister (well If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Davs Min. Virginia Hours 1 □ M 2 X F Yrs 89 Director 212-01-8751 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Carroll Sykesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4925 Arthur Shipley Rd. Funeral 21784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Q Q Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 clothing factory seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Able L. Smith ဂ္ Emmazetta Hylton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Wayne Logue/ son 4131 Salem Bottom Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 6/29/2007 nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of uneral Service License 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Immediate Cause (F disease or condition resulting in death) 181pm 20, **Physician** How /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of):

Examine

IF FEMALE:

physician and the burial-transit

nse

signed by

certificate ha rector, page 2

this

after death.

I Director: A d in by the fu

within 24 hours a

To the Funeral I

completely filled Hospital

Physician/Medical

2

Completed

Be

ျှ

Certification:

Medical

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physiclan:

the

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death

9□Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 2 No 1☐ Yes

26. Place of Death (Check only one)

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pendina investigation 6 Could not be

determined

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

4 Homicide 29a, Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

0005994

29d. Date signed (Month, Day, Year)

lune 25, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

М

State Registra

convert . Inno 295 AR. ner 31. Date filed (Month, Day, 32 Registrar's Signature

	_	For Stete Registrar	State of Maryl		artment <i>tificate</i>			nd Me		iene () og. No.	57	2147
Physician		1. Decedent's Name (First, Middle, Last,)					1	2. Date of Deat Month	h Day	Year	3. Time of Death
Physician /Medica		Blair Lavell						J			2007	11:50 P ^M
Examine		4a. Facility Name (If not institution, give	street and number)		4b. City, T	Town, or	Location of	Death		4c. Count	y of Death	
		Union Hospital			E	:1kt	on			Ce	ecil	
Funeral		5. Social Security Number 6. Sec		vrs. last birthday)	If Under 1	1 Year Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
Director		450-32-5054	M 2□F 79	9 Yrs.				(Oct. 4,	1927		ahoma
put &	-	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation						Т.	10d. Inside City Limits
aryla sho	2		100.									1 to Yes 2 □ No
188-f	901	Maryland Ceci	1	Risin								
with t		10e. Street and Number			10f. Zip (11	Og. Citizen of		ntry?
ath v	<u>a</u>	210 Turtleback Co				219				US		
n 72 hours after death with the Maryland "nature!", or Itams 23a or 28a-f show calcul Examinations to notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13. 1	Nas Decede f Yes, speci	ent of Hi ify Cubai	spanic Origir n, Mexican, I	n? (Spec Puerto Ri	ify Yes or No- can, etc.)		ice - Americack, White,	
s after	Dy L	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give		□ Yes 2	No.	Specify:			Speci	ty: WI	nite
d within 72 hours aft giene. or then "natural", or it is walful Exami	0		Year or Dates:	100 Dans	laada Harre		Ai		1.	10-16-1-1		
	ete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual kind of worl DO NOT use	k done d	urina most a	of working	7	16b. Kind of E	susiness/in	dustry
within sene.	Сотріете	Elementary/Secondary (0-12)	College (1-4or 5+)		rinte					Rail:		
filled Hygie other	ა შ	17. Father's Name (First, Middle, Last)		Jupe	TIHLE	nuei		s Name (First, Middle, N			
d be antal	ň	Edward Lavell									,	
should and Men	<u> </u>	19a. Informant's Name/Relationship (Ty	ne Print)	19h Maifir	a Address	(Street a		500	lair Route Number,	City or Tour	State 7in	Code)
C1 00 -2 00		Helen Lavell/Wife										
1 and Health em 27 thar tr	ŀ	20a. Method of Disposition		b. Place of Dispo			Cour	L, K	ising S	20c. Location		
Department of He Department of He Importent: If item any injury or other once.		1 ☐ Burial 2 X Cremation 3 ☐ F	lemoval from State	cemetery, crer	natory or oth	her place	.	6-19	-2007			
T T T T T T T T T T T T T T T T T T T	-	`4 □ Donation 5 □ Other (Specify)		. T. Foa				e, P	.A. F	Rising	Sun,	Maryland
permit. Depart Import any inj		21. Signature of Funeral Service Licens			Name and			era1	Home,	P.A.		
882 8 8	1	Jule L. II	720		11 S.	Que	en St	reet	. Risir	g Sun	MD 2	
(E-18)		23a. P. 11. Enter the disease, or compf thock, or heart failure. List only or	re cause on each fine.	leath. Vo not ent))	of dying	, such as ca	ardrac or	respiratory arre	est,		Approximate Interval Between Onset and Death
Physician	4	Immediate Cause (Final disease or condition	tsophora	entle	anc.	عر	Tim	n i	Meta	-5-2	515	Onset and beauti
/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):							-	
		Sequentially list conditions,)									
executed In and rial-transit		Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	Due to (bres a con	sequence of):								
and trans		that initiated events resulting in death) Last										
rate be executed thysician and the burial-transit		resulting in deatily cast	Due to (or as a con:	sequence of);								
ate be hysicia the but	2		J									
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examir	Me	IF FEMALE:								- 1		
th ce	2	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pre	gnancy					ate of delive	,
b dea	200	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown	of death 5 □	Other (spe	cify)				, M	onth	Day Year
that the de ted by the a detached to Physic		9 Unknown							1			
res that signed to be dett		Part II. Other significant conditions cor	tributing to death but not	resulting in the ur	derlying ca	use give	n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?
w requir been si should									1 ☐ Ye	s 2 🗆 No	3 Prob	ably 4 Striknown
: The law requires t cate has been signe page 2 should be c	5								24a. Was ar			psy findings available
The law ste has sage 2 sage 2 complete.	5								autopsy perform	ed?	death?	mpletion of cause of
ician: Th	D	25. Was case referred to madical				-	26 Place of	f Death /	Check only one		10105	2010
		eyaminer?	lospital:	2 ☐ ER/Outpatien	3 DQA	Othe	~		5 ☐ Reside		her (Specif	
£ 5 = 17		27. Manner - Death	28a, Date of Injury	28b. Time of		lc. Injury Work			d. Describe ho			γ/
ding I		1 ■ Taturaf 5 □ Pending 2 □ Accident investigation	(Month, Day Year	r) Injury	М		? 'es 2 □ No)				
ital or Attanding P rs after death. al Diractor: After t ied in by the funera Certification:	3	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home, farm, str	eet, factory,	office		28			ber or Rura	l Route Number,
after Dira Jinby		4 Homicide determined	building, etc. (Sp	ecify)					City or Town	, State)		
spita rours naral fillec		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, death	оссипед а	t the time	e. date and r	place, an	d due to the ca	use(s) and m	anner as s	tated
To the Hospital or Attenwithin 24 hours after deat within 24 hours after deat To the Funaral Diractor: completely filled in by the Medical Certifical	٥	(Check only 2 Medical Exeminate)	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, i	in my op	inion, death	occurred	at the time, da	te and place,	and due to	the cause(s)
To the within To the comple	2	29b Signature and title of certifier	7		29c.	License	number		29	d. Date signe	ed (Month,	Day, Year)
F 3 F 5		1		V	~ ~	Va	100	17	1110	61	10/	0-7
		Chance		1 0C \ T			000	6	147	01	10/	
		will blamp and address of pareon who co	mpleted cause of death (item 23a) (Type, i	rint)							-
			MD 111	7 77 4	•		•	000	7974		1.00	
<i>€</i> State		Gloria Simonson 31. Date filed (Month Car Year) 32. Date filed (Month Car Year)	, MD 111 1 32. Figistrar's Si	W. High	Stree	t, S	uite 3	302	E1kton	, MD 2	1921	

			1 - For State Registrar	State of Ma	aryland		artment rtificate			ind Me		giene Reg. No.	2 0 0	7 ?	1 7	77
	Physici	20	Decedent's Name (First, Middle, La.	st)							2. Date of Dea	ath Day	, Yea		ne of De	ath
-	/Media		Bessie Lyngas								June 1	8, 2	2007	6:5	5	a.M
	Examir	er	4a. Fecility Name (If not institution, giv	e street and number)			4b. City, 1	Fown, or	Location o	f Death		4c.	County of D	eath		
			Holy Cross Hospi 5. Social Security Number 6. S		/In ure la	ast birthday)	Si If Under		r Spr		8. Date of Birt		lontgo	mery Birthplace (St	to to or F	oreign
1	Funeral Director		1	_M 2□xF	88	Yrs.		Days	Hours	Min.	(Month, Da)	y, Year)		Country)		
	D		202-10-0695 Usual Residence of Decedent				L			I	Teb. 25	, 1	119 T P	ennsyl	vani	.a
	rylan		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Insid		
	Ba-f a	cto	Maryland Montgo	mery	Si	lver S	Spring	Ī							Yes 2	[] NO
	or 2	Dire	10e. Street and Number				10f. Zip					-	zen of What	Country?		
	deeth with the Maryland rms 23a or 28a-f show rman be marified at	Funeral Director	11612 Fulham St		5i= 11.6	2 42 1	Mar Daned	2090		-:-2 /5	it. Vac as Na		JSA	merican India		
	Item de	Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ 1		s. 13. 1	f Yes, spec	fy Cuba	n, Mexican	, Puerto R	ify Yes or No- lican, etc.)			hite, etc.	XI 1,	
336	ors af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No.	Specify:			ŀ	Specify:	White		
5-0036	2 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation (16a. Dece	dent's Usua	I Occupa	ition	af wadia		16b. K	nd of Busine	ss/Industry		
2121	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of wor DO NOT us	e retired)	OI WOIKIII	9					
21	ed wi	S	12			Sec	cretar	У						overnm	ent	
pu	be fill htal H nd oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)			
78	a Mer narks natic	ဥ	Harry Karvounis					!	Mary '			-	-	7. 0. 1.1		
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Paul G. Lyngas/				•				Route Number					
é,	1 an Heali		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam	e of		Da				or Town, Sta		
5	t: # it		1 □xBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			e of F					ne_21,		•	ring,		zlanć
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a's ahow my njury or other traumatic event, the Medical Exportant must be prefitted at anote.		21. Signature of Funeral Service Licer		Gat						007 Tuneral				ricity	, Lanc
Ba	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1 alille	1/5/											D 2/	0001
			23a. Part1. Enter the disease, or com	plications that caused	the death						respiratory ar		er spr	Approx		
4	Physician		shock, or heart failure. List only Immediate Cause (Final	Cerebro		ular Z	Accide	n+						Onset	and Dea	ath
1	/Medical		disease or condition resulting in death)	a. Due to (or as			100100							-		
а	Examiner		Conventially list conditions	b												
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):										
	ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c												
8760,	icate be executed physician and s the burial-transit	<u> </u>	1030iling in goalin, cast	Due to (or as	a consequ	ience of):										
87	physic the t	e de		d					-							
9 x	ding	Physician/Medical Examin	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv							23d. Date of	deliven		
Box	death e atten	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at	2 Fetal	death 3	Ectopic pre Other (spe						Month	Day	Yea	àг
0	0 0 0	hys	9 Unknown	9□ Unknown												
٥.	law requires that the es been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death be	ıt not resu	Iting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribut	e to the cause	e of dea	th?
ğ	w require been sig should b	edt									101	es 25	No 3□	Probably	4 Unk	inown
ဝ၁	ne law requ s hes been ge 2 shouk	plet									24a. Was		24b. Were	autopsy find to completion	ings ava	ailable
Vital Records,	The ate h page	Completed										rmed?	death	٦?		30 01
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1			
of V	Physician: this certificatal director, I	ဥ	1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatie		R/Outpatien			4 🗆 Nui		e 5 ☐ Resid			Specify)		
ů.	g en	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		Bc. Injury Work			Bd. Describe I	now injur	y occurred			
isi	Attanding r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b		.a. At ho	mo form sta	M (anta-		/es 2□N		Pf Logotion /	Ptront or	d Mumber o	- Cural Cauta	Alventes	
Division	after Direction by	ertif	4 ☐ Homicide determined	28e. Place of Inju- building, etc		me, farm, str	eet, factory,	опісе		28	Bf. Location (S City or Tox			Hurai Houle	wum be	r.
	spital ours ours nerai filled		29a. Certifier 1X Certifying Ph	ysician: To the best of	of my know	viedne death	n occurred a	at the tim	e date and	d place, as	nd due to the	cause(s)	and manner	r as stated		
	24 h	edlcal		niner: On the basis of and manner sta	examinati	ion and/or in	vestigation,	in my op	pinion, deat	th occurre	d at the time,	date and	place, and	due to the car	use(s)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	₩ W	29b. Signature and title of certifier	0 1 5			29c.		number			29d. Dai	e signed (M	onth, Day, Ye	ar)	
	/		· MM	Jahren	DI)		40	064	58	8	6	/18/	07		
	5		30. Name and address of person who	completed cause of d	eath (Item	23а) (Туре,	Print)		(
			Ashish Tolia, M.I). 1500 F	orest	Glen	Road,	Si	lver	Sprin	ng, MD	209	LO			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat		<i>d</i>									
	Registr	ar	AAU T 3 7	Later I also	C. J.	O. A	made !	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23aPtII,25 per ME, C808, 06/26/07dhb

Description of Health and Mental Hygiene Certificate of Death

Reg. No.

Reg. No. - State ANK-INI I LOII 2-20.
State Registrer Por Phy or 6/20/07

1. Decedent's Name (First, Middle, Last) Amended 23a pt1 3. Time of Death 2. Date of Death Month Day Vear **Physician** 2007 7:15 P James Leonard Miles, Sr. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Nursing Home Home Largo
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Prince George's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax **Funeral** Months Days Hours 1 X M 2 ☐ F Yrs. Director 4, 1935 577-46-8126 North Carolina Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County r then "neturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 □ No Directo Prince George's Seat Pleasant Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 518 - 70th St. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott jury or other traumatic even Be Pauline Mitchell Lucien Miles ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 16 Joyceton Way, Upper Marlboro, MD Keith M. Miles/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Department c important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 6/7/2007 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Queta Wash., DC 20019 4001 Benning Rd., NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** 3 Weeks Acute Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Intra Granial Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine YED BY MEDICAL EXAMINER To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical CERTIFICATIONYAPPRO IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnanci in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ó 9☐ Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2∏ No 1 Tes 2 🕅 No 1 Tyes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TANO After this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural A hours after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 2 0 2007

32. Registrar's Signature

8M amu

Sobhan Mathew, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

D47604

3048 Mitchellville Rd., Bowie, MD

June 6, 2007

20716

DH-10

31. Date filed (Month, Day, Year)
JUN 2 0

32. Registrar's Signature

State Registrar Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 4c Per Phy, qc 6/26/07 Certificate of Death Amended # 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 17, 2007 Vear **Physician** 9:45 P E11en McMahon Marv /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's
Charles
9. Birthplace (State or Foreign 51 Highland Place Indian Head 8. Date of Birth
(Month, Day, Year)
Dec. 9, 1909 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours Washington, DC 1 □ M 2 X F 97 577-01-1819 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. Count 10a. State "natural", or items 23a or 28a-f shovedical Examiner must be notified at 28a-f shov Charles 1 ☐Yes 2 No Indian Head Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other than "natural", or items 23a or 2 20640 USA 51 Highland Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 21021 No Baltimore, Maryland 21215-0036 Specify: Specify Completed by 3₺Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking File Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha M. Vallandingham Samuel 1 R. Posey ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traum once. 51 Highland Place Indian Head, Maryland James R. Caparrotta Sr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/21/2007 Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signat of Funeral Service Licensee . Kake 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed the burial-tra Due to (or as a consequence of): P.O. Box 68760, physician as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Dav Year for in the past 12 months? 1 ☐ Yes 2 XXNo 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2. Who has ge certificale 1∏ Yes ď 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 3□ DOA 2 ER/Outpatient 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

funeral After

n 24 hours after death.

ne Funeral Director: Af

the Hospital or Attending Physician: Medical within 24 9 State Registrar

29b. Signature and title of certifier

1 🛚 Natural

2 Accident

3 ☐ Suicide 4 Homicide

(Check only

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

1 Tyes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

Three Notch Rd. Holymood MD 20136 aven, MD 24035

32. Registrar's Signature Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

М

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Milianv Mulvadi 1000 AM une 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 226 Lee Street Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar 25, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F 53 Director None Indonesia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 X Yes 2 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Aut: If tem 27 is marked other than "natural", or items 23s and it flem 27 is marked other than "natural", or other traumaite event, the Medical Examiner must any or other traumaite event, the Medical Examiner must 226 Lee Street Funeral Indonesia Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Asian ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Travel Agent Travel Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lie Ing Fen Liauw Chunto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wira Kumala Tedja (Spouse) 226 Lee Street, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/17/07 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Lig reli Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearl failure. List only one cause on each line. Approximate Interval Between Onset and Death lioblastoma multi Immediale Cause (Final metastatic **Physician** months disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1□ Yes 2No To Be 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly W. Mercer 9707 Medical Center Drive Rockville, MD 20850 W. Mercer 31. Date filed (Month, Day, Year) State

JUN

19

2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

32. Registrar's Signature

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064115

29d. Date signed (Month, Day, Year)

June 17, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 2**00**7 4:10 AM **Physician** JOAN MCDONALD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth July 13, 1930 Washington D.C. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🛱 F 76 Yrs. 214-28-4775 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County if Health and Menial Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, It a Modical Examinar mast be notified at 1 XYes 2 No Gaithersburg Montgomery MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20877 233 Lower Country Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) ould be filed within 72 I Mental Hygiene. National Institute Elementary/Secondary (0-12) College (1-4or 5+) of Health Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Dedge John Schaeffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gaithersburg, Md. 20877 233 Lower Country Dr. Robert F. McDonald (Son) Date 18, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition June permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, VA Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Services Licens OUC. 10 East Deer Park Dr. Gaithersburg, MD 20877 urtis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Acute cerebrovascular accident 2 week Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): nding physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. Cholangiocorcinome weth liver 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Sypectension. 24a. Was an autopsy performs astases. Breast careinoma. Syperlypidencia 1 Yes 2 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other. 4 V Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 🗍 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D04115 Jane 18,2001 14. Robert Bushbarano 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSLL AVENUE 208117 12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June 2007 18 9:15 p.M Mary Magdalene Mills 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Dorchester Cambridge 1400 Glasgow Street If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ☐ M 2 🔀 F Maryland May 3, 86 214-07-8252 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Cambridge Dorchester MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 1400 Glasgow Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 █XNo Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Goldsborough Johnson Lena Ruark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1400 Glasgow St., Cambridge, MD 21613 W. Russell Mills husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cambridge, MD Dorchester Mem. Park 6/21/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tuneral Service Licensee 21. Signatur Thomas Funeral Home P.A. Cambridge, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be r

e filed within 72 hours after dial Hygiene.

other than "natural", or Item rent, the Medical Examiner.

Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other

fitem 27 is n r other traun

permit. Pages ' Department of H Important: If ite any Injury or ot once.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

death with the Maryland

as the burial-tran ase for

Examiner

Be Completed by Physician/Medical

and the attending physician certificate To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	disease or condition	a. 1200	E 64 1	3K K03P			1 Wet
	resulting in death)	full to (s consec	juence of):				Zweeks
iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to lor as a consec	quence of):				
dical Exan	that initiated events resulting in death) Last	C	quence of):				
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 46 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of of 9 □ Unknown	al death 3 □Ectopic			23d. Date of de Month	livery Day Year
Completed by Ph	Part II. Other significant conditions of Chars tive Ita	contributing to death but not res CIFAILURE EmpleSem	, Swalle	cause given in Part I.		2 No 3 P	utopsy findings available completion of cause of
ŏ	25. Was case referred to medical			26 Place of D	eath Check onlone	Mo I I I I I I I I	2/2140
To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	Other	Home 5	6 □Other (Spe	ecify)
ation: 1	27. Manner of Death 1 □ Matural 5 □ Pending □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Sertifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
Medical Certification:	29a. Certifier (Check only one)	nysician: To the best of my kn miner: On the basis of examin and mapmer stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier	- N/		29c. License number	29d.	Date signed Mon	

Registrar

State

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARR

JUN 2 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23a per me, 8868, 06/29/07dhb

Reg. No. 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month Newborn Year **Physician** 8:24P M 2 rest ing 15 2007 /Medical 4a. Faqility Name (If not institution, give street and number, 4h City Town or Location of Death County of Death Examiner Colombia ward HO 602 Coicuty Exam If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Social Security Number **Funeral** 1 M 2 H F Months Days Hours 71 223-46-9249 18 1936 Virginia April Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Laurel MD Howard 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ns 23a or i must be n USA 9377 Whiskey Bottom Road 20723 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, items Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 HNo Baltimore, Maryland 21215-0036 'natural'; or Specify Specify: white þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than the 7th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 7 is marked c traumatic ever Polly Shepherd Charlie Remines ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Phyllis Corby/daughter 1270 Shaffersville Road, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Newberry Cemetery 6/20/2007 Raven, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisansee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 M00160 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Complications of incarcerated immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) paraesophageal **Physician** (or as a consequence of) /Medical hernia Examiner Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic Examine Cardiovascular Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.Ó. Box 68760. physician s the buria Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy signed by the atte Month Day Year in the past 12 mo 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant populations contributing to death but not resulting in the underlying cause given in Part I. þ 748-110 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown plnode Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy perform 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1X Yes 2 1. Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Beath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No neral Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Sie 29c. License number 29d Date signed (Month, Day, Year) Steve 16, ress of person who completed cause of death (Item 23p) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 200

(2)

1 W 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 21:13 PM Charles Robert Nettles JUNE 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7, Age (In yrs. last birthday) Days 1 X M 2 □ F 68 423-50-4127 04/02/1939 ALUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County Hagerstown 1 □Yes 2X No Washington 10f. Zip Code 21740 10g. Citizen of What Country? 10e. Street and Number US 12321 Walnut Point West Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Black 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County School School Bus Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ola Lee Packer Jimmy (unk) Nettles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12321 Walnut Point West, Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type. Print) Ethel M. Nettles / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/25/2007 Rose Hill Cemetery Hagerstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRADYCAPDIA Due to (or as a consequence of): MYPERKALEMIA Sequentially list conditions, tay leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): FENAL PISEASE END STAGE Due to (or as a consequence of): IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DABETER MYPETTENGLON AMEMIA 1 Yes 2 No 3 Probably 4 Unknown MYPERMOUESTPOLEMIA. 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe JYMOROME PULMONARY 1□ Yes 2□ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner death certificate be executed burial-transit physician the Division or Vital Records,

P.0.

Physician /Medical

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore,

page 2 s certificate this After t after death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu JH-11

Hospital or Attending

State

25. Was case referred to medical examiner? 1 Yes 2 11 No 27. Manper of Death

3 Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 00002327

MD 21740

29d. Date signed (Month, Day, Year) U

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 MAUGRITOWN MILL ST.

31. Date filed (Month, Day, Year) JUN 2 2 2007 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Month 10:35 PM **Physician** June 12, LUU NGUYEN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 209 Grange Hall Drive Gaithersburg Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2**X** F Yrs 90 Director 185-62-1342 Vietnam March 25, 1917 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Tyres 2 □ No Director Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20877 209 Grange Hall Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2K Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Asian Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 10 Seamstress 18. Mother's Name (First, Middle, Thi Suu Nouyen 17. Father's Name (First, Middle, Last) Be Cong Nguyen ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 209 Grange Hall Drive, Gaithersburg, MD 20877 Oanh Mudd / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Gate of Heaven June 15 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 □ Donation 5 □ Other (Specify 2007 Silver Spring, MD 21. Signature of Funeral Servi 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 RACI 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Acute Event Two Days /Medical Due to (or as a consequence of) **Examiner** 20 Years Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 20 Years <u>Hypertension</u> burial-tran Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical 20 Years Chronic Kidney Disease IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical r. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 2 Medicai Exam within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat D004020 June 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASSAR, M.D. I ONE EXECUTIVE PARK CT, GERMANTOWN, MD 20874 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 1 9 2007

Registrar

			1 - State State Registrar	of Maryland / Dep <i>Ce</i>	artment of Health <i>rtificate of Deal</i>			ene	07	1.07
	专		Decedent's Name (First, Middle, Last)				2. Date of Death		V	3. Time of Death
	Physicia /Medic		Francis S. Nero				Month 6		Year 57	0332 A M
	Examin		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location	ion of Death		4c. County o	f Death	
		-3	Coastal Hospice At The 1	ake	Salisbury			Wico	mice	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Months Days Hour	nder 24 Hrs. Irs Min.	8. Date of Birth (Month, Day,) 01-01-19		9. Birthp	lace (State or Foreign try) aware
	Director		222-09-0000	86 Yrs.			01-01-19	21	рета	aware
	and	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl f sho	ō	Delaware Sussex	Laurel						1 □Yes 2 No
	the 28a-	Director	10e. Street and Number		10f. Zip Code		10g	j. Citizen of W	hat Coun	try?
	3a ol	0	9088 Woodland Ferry Roa	ad	19956			U.S.A.		
	death ms 2 r mus	Funeral	Armed F	cedent Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	o Origin? (Spe	cify Yes or No-		- Americ	an Indian,
٥	hours after death with the Maryland tura!", or Items 23a or 28a-f show al Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 11/2 ☐ Yes	a 2 No Army	1 ☐ Yes 2 No Spec			Specify:		
2-003e	ural",	d by	3X Widowed 4 □ Divorced Year or		dentie Heyel Occupation		16	Sb. Kind of Bus		ite
ភ្ន	"nat	Completed	15. Decedent's Education (Specify only highest grade completed	(Give	edent's Usual Occupation e kind of work done during r DO NOT use retired)	most of workir	ng	ob. Kiliu di Dus	iness/inc	lustry
7	withii ene. than he M	Ĕ	Elementary/Secondary (0-12) College	(1-4or 5+)	-employeed Ca			Cabine	etry	
ס ס	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)				(First, Middle, Ma	iden Surname	9)	
yland	fenta rked ric ev	To B	G. Santo Nero			Teodor	a Nero	(unkr	lown)	
a S	should by man		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street and Nu	umber or Rura	l Route Number, (City or Town, S	State, Zip	Code)
Z	alth a alth 27 k		Cynthia Matthews (daugh	iter) 9088	Woodland Fe	rry Rd	. Laurel	, De. 1	9956	
e e	of He of He ritem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	D	ate 20	Oc. Location - 0	City or To	wn, State
Ĕ	Pag ment ant: If ury o		4 □ Donation 5 □ Other (Specify)		ows Cemetery	June	15,2007	Laure1	, De	laware
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Address of Fa annigan, Short	acility t.Disha	aroon F.I	н		st St.
Ц	70 E # 9		Holly Short-Hann	Lojus. —	-			Laur	el,	De. 19956
		,	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not er each line.	nter the mode of dying, such	h as cardiac o	r respiratory arres	it,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ngestive He	ut Forlan	hui				
	/Medical Examiner		Due t	o or as a consequence of):	æ.					
		-E	Sequentially list conditions, if any, leading to immediate b. Due to	o (or as a consequence of):						
	uted I Insit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c						- 1	
ĵ.	execting and ital-tra			o (or as a consequence of):						
8/60	ficate be executed physician and s the burial-transit	dical	d						\perp	
9	ng ph	Med	IF FEMALE:							
X P P	death certif e attending id for use as	an/I	23h Was decedent prograph 23c. if yes, c	outcome pf pregnancy birth 2 Fetal death 3	□Ectopic pregnancy			23d. Date Mon		ery Day Year
	e dea the at red fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)					Da ,
٦.	hat the day detack		Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in P	Part I.	23e, Did toba	cco use contri	bute to th	ne cause of death?
Vital Records,	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a	i by		rosbbulinem.			1 ☐ Yes			ably 4 □Unknown
Ö	v requ	Completed	Cat idet 1	, ,			24a. Was an	24h W	lere auto	psy findings available
ě	sician: The law certificate has t irector, page 2 s	mpl	GOSTVO INFSTRA	lemorrhy			autopsy pertorm	ed2 d	rior to co eath?	mpletion of cause of
<u>n</u>		ပ္ပ	25. Was case referred to medical		26 D	Place of Death	1 Yes 2 (Check only one)	ZNO 1	☐Yes	2 No
	nysician: nis certific director,	o Be	examiner?	Inpatient 2 ☐ ER/Outpatie	1 Other:		me 5 ☐ Residen		r (Snecit	iv)
0	g Phy er this eral d		27. Manner of Death 28a. Da	te of Injury 28b. Time Injury Injury	of 28c. Injury at		28d. Describe how			<i>y</i> /
0	ath. ir Aft	atio	Accident investigation	onur, Day Fear) Injury	M 1 ☐ Yes	2 □ No				
IVISION	r Atte er der recto	Certification:		ce of injury - At home, farm, s Iding, etc. (Specify)	treet, factory, office	2	28f. Location (Stre City or Town,		r or Rura	al Route Number,
2	pital or Attending lours ter death. leral Director After filled in by the funer									
	d the	Medical	29a. Certifier Check only one) Certifying Physician: To the Medical Examiner: On the	the best of my knowledge, dea basis of examination and/or i anner stated.	atn occurred at the time, dat investigation, in my opinion,	ite and place, n, death occurr	and due to the cau red at the time, dat	use(s) and mai te and place, a	nner as s ind due t	tated. o the cause(s)
	To the Pyvithin 2. To the Populet	Mec	29b. Signature and title of certifier	7/ 4	29c. License numb		290	d. Date signed	(Month,	Day, Year)
1	_ Da		WOEN4	MY	026	278		6-11	-0	7
j	20		30. Name and address of person who complet	use of death (Item 23a) (Type	, Print)		0 ()			
_	1/2			6stel Hospine	PU BUX 173	3	Solish	MD	218	132
	Sta			. Registrar's Signature			3)			
	Registi	ar	JUN 1 4 2007	Brown . K 1	MONEY)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#21, perFH, G869, 7/2707, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month NORMAN STANLEY ODEN, JR. Tune 25 1754 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SIL AGNES HEALTHO BALTIMORE CITY Social Security Number In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days 1**∏** M 2□ F Hours 81 Yrs. Director 226-26-4983 7-26-1925 VA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at BRANDYWINE Director MD. PRINCE GEORGES 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 16150 INHERITANCE DRIVE 20613 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Types 2 No NAVY
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th STEAMFITTER U.S.GOVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Ments item 27 is marked ၉ NORMAN STANLEY, SR. MAUDE EMMA SANBORN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH ODEN-SPOUSE 16150 INHERITANCE DR. BRANDYWINE, MD. 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State ō 1 □ Maurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or TRINITY MEM.GARDENS 6-30-07 WALDORF, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee MOO479 ▶ Michael Raymond PER DVR LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's **Physician** Known /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy rmeg. 2 No 1□ Yes Vilal after death.

Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47353 June 25, 2007 30. Nam and address of Jerson who completed cause of death (Item 23a) (Type, Print)

90. Nam and address of Jerson who completed cause of death (Item 23a) (Type, Print)

Pathwore, Maryland 21229 11+1 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

16a. Decedent's Usual Occupation

Cleaner

1 XYes 2 No Specify: Salvadoran

18. Mother's Name (First, Middle, Maiden Surname)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 12, 2007

Maria Paula Osorio

(Give kind of work done during most of working life. DO NOT use retired)

White

Approximate Interval Between Onset and Death

Year

Day

10, 2007

Specify:

16b. Kind of Business/Industry

Cleaning Company

death with the Maryland fshow ms 23a or 28a-f shor must be notified at Director Funeral Items Examiner Pages 1 and 2 should be filed within 72 hours after 'n, altimore, Maryland 21215-0036 "natural" Completed the Medical n and Mental Hygiene. Be 2 traumatic Department of Health ar Important: If item 27 is any injury or other trau

þ

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Roque Iraheta Amaya

6th

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner The law requires that the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

To the Hospital or Attending Physician:

Examine physician and the burial-transit Physician/Medical attending p signed by the a ģ been si Completed has Be ို this Certification: Director within 24 hours at To the Funeral D completely filled in Medical

27. Manner of Death

1 X Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

29b. Signature and title of certifie

Dr. Ann Burke

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8409\ 15\text{th}\ \text{Avenue}$ 19a. Informant's Name/Relationship (Type. Print) Maria Osorio/sister Hyattsville, Maryland, 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 06-24-2007 El Salvador Family Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe Preeclampsia disease or condition resulting in death) Due to (or as a consequence of): Intracranial Hemorrhage Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disseminated Intravascular Coagulation Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 X Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 XYes 2 ☐ No Month 5 ☐ Other (specify). 4☐Pregnant at time of death 9□Unknown June 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an performe 1⊠ Yes 2 □ No 25. Was case referred to medical examiner? Declined 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State Registrar

KO

31. Date filed (Month, Day, JUN 1 9 2007

5 ☐ Pending investigation

6 ☐ Could not be

determined

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

and manner stated.

ems

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD36793

1 ☐ Yes 2 ☐ No

1500 Forest Glen Road

Silver Spring, Maryland, 20917

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month 09:33 A^M Carol J. Peterson June 2007 27. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**1** F 57 Yrs. Director 221-36-8676 Dec. 17, 1949 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov al Hygiene. other then "naturel", or Iteme 23a or 28a-f ehov vent, the Madical Examinar must be notitied at 1 Yes 2 □ No Directo Cecil Maryland Port Deposit 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. #6 Maple Hill Rd. 21904 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fill iment of Health and Mental H tent; If item 27 is marked ot Francis Sielski Catherine John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clayton Peterson (Husband) #6 Maple Hill Rd. Port Deposit, MD 21924 other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Family Cremation permit. Page Department of Important: If eny injury or once. 07/03/2007 4 ☐ Donation 5 ☐ Other (Specify) Wilmington, DE Services and Address of Facility Zellman Mitchell Smith Funeral Home 21. Signature of Funeral Service Licensee 123 S. Washington St. Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiovascular /Medical Due to (or as a consequence of): Examiner 1abo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Box 68760, that initiated events resulting in death) Last or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BKz Completed 2 No 3 x robably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No : After this certifical funeral director, i or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 raigtown 31. Date filed (Month, Day, Year)
1111 0 3 2007 State Registra

07-04942	
Jeremy Pruitt	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Jeremy Pruitt	State of Maryland 1- For State Registrar	Department of H Certificate of D		ygiene Reg. N	No.	
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month Da	v Year	Time of Death
Medical Examiner	JEREM 4a. Facility Name (if not institution, give street and number)		City, Town, or Location of Death	June 29, 200	7 4c. County of Death	0035 hrs
4	McCready Memorial Hospital	1	risfield		Somerset	
Funeral	5. Social Security Number 6. Sex 7. Ag	` ' -	Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Birthr Foreign	place (State or
Director	218-77-0582 1X M 2 F	Yrs.	Months Days Hours Min 4 27	02/02/20	O7 Coun	^{try)} Maryland
e a X	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			1	0d. Inside City Limits
nd nd skow ;	Maryland Somerset	Marion	Station			1 Yes 2 XNo
the Maryland as or 28a-f sh	10e. Street and Number		f. Zip Code	10g. (Citizen of What Country	y?
h the h the hottling	6079 Charles Cannon Road		21838		USA	
r death with or items 23 must be no	11. Marital Status 1 X Never Married 2 Married Armed Forces		ecedent of Hispanic Origin?(Sp specify Cuban, Mexican, Puerto		14. Race - America White, etc.	n Indian, Black,
fter de F., or i	3 Widowed 4 Divorced If Yes, Give Yeer	X No	s 2 X No specify:		Specify: Whi	te
natura x-min	15. Decedent's Education (Specify only highest grade cor	npleted) 16a. Decedent's U	Isual Occupation (Give kind of vorking life, DO NOT use reti		b. Kind of Business/Ind	
5-0036 ed within 72 hours aft lygiene. other than "natural" the Medical Ex mine Completed by	Elementary/Secondary (0-12) College (1-4 or	5+)	or working life. BO NOT dise real			
d with space of with space of the real of	17. Father's Name (First, Middle, Last)	N/A	18.Mother's Name	(First, Middle, Maid	(/A len Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than narked other than for event, the Media	Charles Jeremy Pruitt		Elizabe	th Ashley	Windsor	
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	dress (Street and Number or I	Rural Route Number	, City or Town, State, Z	^(ip Code) 21838
and 2 and 2 (ealth a	Elizabeth Pruitt (Mother) 20a. Method of Disposition	6079 20b. Place of Disposition	Charles Cannon (Name of cemetery,		arion Stat	
nore ages l nt of H it: If i	1 X Burial 2 Cremation 3 Removal from St	- 1				
Baltimore, MD permit. Pages I and 2 shc peperment of Health and Department of Health and Important: If item 27 is injury or other traumanti	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	St. Paul's			arion Stat SONS FUNER	
ZEE E	Wildly Both Sockhold F Mary Beth Bradshaw-Pruitt	306	W. Main Stree	t - Crisf	ield, MD 2	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.			r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
kaminer	Immediate Cause (Final disease or condition resulting in death) a. Sudden une	<u>xplained death in</u>	infancy (SUDI)			Death
	Sequentially list conditions, b					
niner	if any, leading to immediate Due to (or as a constraint Cause. Enter Underlying Cause	equence of):	•			
ed nsit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a const	equence of):	· · · · · · · · · · · · · · · · · · ·			
iox 68760, eath certificate be executed attending physician and for use as the burial - transit /sician/Medical Ex	YUNPENDED AMENDED O	-				
'60, ate be execut ohysician and he burial - tra	#23a,27,28 IF FEMALE: 23c. If yes, outcor	Ba-f.perME.g871.	9/10/07 TT		23d. Date of delivery	
k 687	23b. Was decedent pregnant in the past 12 months?	2 Fetal d	eath 3 Ectopic pregna		Month Day	y Year
). Box it the death c by the atten sched for us	1 Yes 2 No 9 Unknown g Unknown	time of death 5 Other	(Specify)			
that the d tetached detached by Phy	Part II. Other significant conditions contributing to deat	but not resulting in the unde	rlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
s, P.O. irres that the signed by d be detach				1 Yes 2	No 3 Probat	oly 4 Unknown
ords w requ as beer shoul				24a. Was an autopsy	prior to con	osy findings available npletion of cause of
Records, The law requires ficate has been signage 2 should be Completed				performed 1 Yes 2		2 No
ital ician: s certif	25. Was case referred to medical examiner?	nt 2 ✓ ER/Outpatient 3	26.Place of Death (Check DOA Other: Nursin			
Division of Vital Records, liospital or Attending Physician: The law requir 24 hours after death. Fineral Director: After this certificate has been stelly filled in by the funeral director, page 2 should all Certification: To Be Completed	1 ✓ Yes 2 No Impate 27. Manner of Death 28a. Date of Inju (Month, Day, Y			g Home 5 Res 28d. Describe how	injury occurred	
Division ospital or Attending tours after death. Theral Director: After filled in by the fune Certification:	Natural 5 Pending End 6/29		1 Yes 2 X No	unk		
ivisi or Att Direct lin by Lifica	3 Suicide 6 X Could not be 28e. Place of In	jury - At home, farm, street, fa	ate office to their contracts	28f. Location (Stree	et and Number or Rural	Route Number, City
Dispital special interal y filled	20a Certifier	ound in residence				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	one) 2 ✓ Medical Examiner: On the basis of examiner:					
To with To con	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month	, Day, Year)
	Aplina Brassell MI		O.C.M.E.	Ju	une 29, 2007	
	30. Name and address of person who completed cause of d	, ,	Street Politimore MD	21201		
State	Melissa Brassell, MD Assistant Medical 31. Date filed (Month, Day, Year) 32. Registra	's Signature	Street, Baltimore, MD	21201		
Registrar	31. Date filed (Month, Day, Year) 32. Registra	J. Great				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 1 1 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 14, June 2007 3:50 P. M Harry Austin Pearson, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 2712 Shawn Court. Ft. Washington Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** Months Days 1XM 2□F Hours Min. Wash., D.C. 7/16/16 Director 578-07-0547 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at TYEYes 2 □ No Ft. Washington Director Md. P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 2712 Shawn Court 20744 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: African-1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: 3 XWidowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs. Letter Carrier U.S. Postal Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumation. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Chapman Harry A. Pearson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Austin Pearson, Jr. /Son 2712 Shawn Court, Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 6/16/07 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Hars awashington & Sons Co., Inc. any 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed inding physician and use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the death certificate attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year 5 Other (specify) P.O. I cate has been signed by the a page 2 should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimer's Dementia 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 🗆 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one)

Division or Vital Records, this certificate Physician: director, funeral After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 - Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32800

29d. Date signed (Month, Day, Year)

June 15,2007

State Registrar

30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Herbert Washington M.D. e filed (Month, Day, Year) 32. Registr 11701 Livingston Rd.# 205,Ft. Washington,Md. 20744 31. Date filed (Month, Day, Year)
JUN 1 9 2007

29b. Signature and Mile of certifier

			Plea	se Type or							ible.	
		-	For State Registrar	State o	f Marylan		rtment of H		d Mental Hy	giene Reg. No.	1.00	
Ī	Physicia /Medic		1. Decedent's Name (First, Middle Lela Arvell						2. Date of De Month June 1.	Day 2007	Year	3. Time of Death 4:40 P M
	Examin	er	4a. Facility Name (If not institution Washington Adve	-			4b. City, Town, or Takoma		eath		y of Death gomer	У
	Funeral Director		5. Social Security Number 441–22–7555	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 80	last birthday). Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da Dec 2,	1926	Coui	place (State or Foreign ntry) homa
	Maryland -f show lied at	tor	Usual Residence of Decedent	e George'		y, Town or Lo Hyatt	cation					10d. Inside City Limits 1X Yes 2 □ No
	with the 3a or 28a t be notii	I Director	10e. Street and Number 3110 Lancer	Place			10f. Zip Code 207	82		10g. Citizen of	What Cou USA	ntry?
350	u within 72 hours after death with the Maryland spen. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Man 3 ☒ Widowed 4 □ Divorced	ried Armed F	2⊠No ive		Vas Decedent of H f Yes, specify Cuba I □ Yes 2½ No	Ispanic Origin? an, Mexican, Po Specify:	(Specify Yes or No uerto Rican, etc.)	Spec	ace - Ameriack, White,	
9500-6121	filed within 72 hou Hygiene. other than "natura ent, the Medical E	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed,	1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired memaker	ation during most of d)	working	16b. Kind of Own I		dustry
⊂	be file tal Hy d othe event,	To Be C	17. Father's Name (First, Middle, John W. Hayne						Name (First, Middle tha C. Jon	*	ime)	
Mary	s 1 and 2 should I f Health and Men fem 27 Is marke other traumatic		19a. Informant's Name/Relations Pamela Sprouse		er				r Rural Route Numb akoma Parl		n, State, Zi 20912	p Code)
Baltımore,	o = i		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	3 ☐Removal from	State 20b. F		sition (Name of natory or other place n Cemetery	ce) 6/	Date 20/07	20c. Location Brentw		own, State Maryland
Baltı	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service	nee &	asch	Ga		neral H	ome, P.A.	Hyatts	timor ville	re Avenue e, MD 20721
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	caused the deat each line.	th. Do not ent	er the mode of dyir (ACM) 1.man	ng, such as car	ediac or respiratory a	Ali		Approximate Interval Between Onset and Death
3760,	death certificate be executed e attending physician and d for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	(or a sonsed	2h	Vena	us s	theemb	ons		
O. Box 68	he death certificate be the attending physici thed for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	1 ☐Live	utcome pf pregn birth 2 Feta gnant at time of a nown	aldeath 3	Ectopic pregnanc Other (specify)	y			Date of delivery	very Day Year
rds, P.	The law requires that the de ate has been signed by the a bage 2 should be detached it	þ	Part II. Other/significant condit	ions contributing to	eath but dot res	ulting in the u	oderly ng cause giv	ven in Part I.		tobacco use co		the cause of death?
al Records,		Completed	_ Colenai	y Me	lenf	des	gas l	places	perl 1∐ Yes	formed? 2 No	death?	topsy findings available ompletion of cause of 2 □tNe
or Vital	hysiciar this certif al directo	To Be	25. Was case referred to medial examiner? 1 Yes 2 No	Hospital: 1 [ER/Outpatie		ner: 4 🗆 Nursii	Death (Check only	sidence 6 🗆 C		ify)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could	ng (Mo	e of Injury nth, Day Year) be of injury - At h ding, etc. (Speci	28b. Time of Injury ome, farm, strify)	Wo	ryat rk?]Yes 2∐No	28f. Location	Street and Numbers, State)		ral Route Number,
	Hospital of the Hospital of Funeral C	Medical Ce		ing Physician: To the								
	To the within To the comple	Mec	29b. Signature and litle of certifi				29c. Licens	se number	47	29d. Date sig	ned (Month	Day, Year)
,	B		30. Name and address of person	n who completed ca	use of death (ite	m 263) (Type,	Print)	Tak	ome Pa	cut /	40	209/2

State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl		artment of H rtificate of I		d Mental Hy	/giene	7 -7	21495
	Physic		Decedent's Name (First, Middle, Las	P	10		-	2. Date of De Month	eath Day	Yeer	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)	DI	4b. City, Town, or	Location of [Death		ZooT ty of Death	6 ICA
	Funeral Director		5. Social Security Number 6. Sec. 490 34 5944	7M 2CIF	yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D.	rth	Coun	Aace (State or Foreign try) SOURI
	yland		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation					Od. Inside City Limits
	the Ma	Funeral Director	MD PRINCE GI	EORGES C.	APITOL H	EIGHTS 10f, Zip Code	-		10g. Citizen of	What Coup	Yes 2 □ No
	23a or	al Di	4211 ALTON STREET			20743	,		-	D STA	•
036	permit. Pages 1 and 2 should be itled within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic svant. I've Metical Examinar must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married XXX Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※※ No lf Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes XX No	spanic Origin n, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	o- 14. Ra	ce · America ack, White, e	an Indian,
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 7 TH		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of	working	16b. Kind of E		lustry
	al Hygi d other went, I	Be Co	17. Father's Name (First, Middle, Last)		HOME	MAREK	18. Mother's	Name (First, Middle	DOMES , Maiden Suma		
Maryland	hould to d Ment marked matic s	Į.	JAMES WILSON 19a. Informant's Name/Relationship (T	une Print)	10h Mailie	Address (Street		RET LANDI			
	and 2 s alth an 27 is or trau	i	KATHERINE PATOPIE	/ DAUGHTER		ALTON ST		r Rural Route Numb CAPITOI	L HEIGHT		
nore	ages 1 and of He	3	20a. Method of Disposition XXBurial 2 □ Cremation 3 □ I	Removal from State		natory or other place		Date	20c. Location	· City or Tox	wn, State
Baltimore,	permit. P Depertme Importsn any injur.		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	1.**		VETERANS Name and Address MARSHALL	s of Facility S FUN	ERAL HOME	OF MAR	YLAND,	INC.
ı			23a. Part Enter the disease, or comp shoet, or heart failure. List only o	ne cause on oach line.			, such as car	diac or respiratory a	TLAND,	MD 207	Approximate Interval Between
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	u		t ST	ROKe	イ			Onset and Death
	Examiner		Sequentially list conditions	6.	rtens	رهام					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (as a cons	sequence of): tes m	elletu	5				
58760,	ficate be executed physicien and is the burial-transit	ai Exa	resulting in death) Last	Due to (or as a cons	sequence of):						
_	rtificate ng phys	Medical	IE EENALE.	d.							WSIII.
.O. Box	law requires that the death certifi as been signed by the ettending I 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)				ate of deliver onth	y Day Year
ecords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co.	ntributing to death but not	resulting in the ur	derlying cause give	n in Part I.				e cause of death?
Vital Rec	The ate h page	Completed		-					osy rmed?	Were autopoption to comdeath?	sy findings available ipletion of cause of
	2 9 9	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ER/Outpatient	! Otho		Death <i>Check only o</i>	100	(0 6.)	
sion of	ding Afte fune	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injury Work			now injury occur		
UIVISION	spital or Attane ours efter death neral Director: filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	oer or Rural	Route Number,
	To the Hospital or Attan within 24 hours efter deati To the Funeral Director: completely filled in by the	Medical	one) 2 medical Examin	sician: To the best of my laner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time estigation, in my opi	e, date and pl inion, death o	ace, and due to the ccurred at the time,	cause(s) and made,	anner as sta and due to t	ted. he cause(s)
	0.4 € 6 € 6 € 6 € 6 € 6 € 6 € 6 € 6 € 6 €	Σ	29b. Signature and title of certifier			D - 5	number 1520		29d. Date signe		
	90		30. Name and address of person who co	DAD, MD.	tem 23a) (Type, F	Souther	n Av.	e SE #	310	WAS HI	10650H DO
	Sta Registra		31. Date filed (Month, Day, Year) JUN 1 9 2007	32. Registrar's Sig	ature					2	10032

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Tammy Kay Perrott June 19 2007 09:40a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🔀 F 216-74-7386 Director 09/30/1964 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ust be notified at Middletown MD Frederick 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4604 Pinewood Trail 21769 US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 6 more, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) NA College (1-4or 5+) NA NA permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other 1 any injury or other traumatic event, the once. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Allen Perrott Carolyn Ann Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Concord Street, Hagerstown, MD 21740 Shantell L. Shubert / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory | 06/21/2007 | Smithsburg, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician are the burial-t Physician/Medical attending p for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 21 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes No 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, 124 hours after death, ne Funeral Director: A bletely filled in by the fu within 2

WH-C State

Registrar DHMH 17 Rev 1/2001 (Check only one)

31, Date filed (Mor

29b. Signature and title of certifier

30. Name and address of person who come

2

and manner stated.

ause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

6535 N Clarkent Ste ITO Pilisan

Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours a within 24

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

JUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

02

29c. License number

29d. Date signed (Month, Day, Year)

21804

		U 1550	For State Registrar			of Ma	-		rtment of F	Death		Reg. No			1490
	Physici		1. Decedent's Name (First, Middle, Last) Erwin L. Parker							Month	2. Date of Death Month Day Year Jun 17, 2007 3. Time of Death 08:45 A				
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Frederick								4c. County of Death Calvert				
200	Funeral Director		5. Social Security Number 212-82-2377		7. Age (In yrs. last bir 1 ☑ M 2 ☐ F 45			rs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Sep 6, 1961) (9. Birthplace (State or Foreign Country) Maryland	
Baltimore, Maryland 21215-0036	show	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Calvert Prince Frederick									side Clty Limits			
	a with the National 3a or 28a-1		10e. Street and Number 2105 Adelina Road					10f. Zip Code		10g. Ci	tizen of What C				
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatin and Mental Hygiene. I ben't of Heatin and Mental Hygiene. In: If iten 27 is marked other than "natural", or items 23a or 28a-f show nt: If iten 27 is marked other than "natural", or items 23a or 28a-f show nt; If we dealer Examiner must be notified at ity or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Marital Status 1 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evarmed Forces? 1 1 Yes, 2 No of If Yes, Give Year or Dates:				er in U.S. 13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric					14. Race - Am Black, Wh Specify: Bla	ite, etc.	ian,	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Builder 16b. Kind of Business/Ind Construct							
			17. Father's Name (First, Middle, Last) 18. M						18. Mother's Name	Name (First, Middle, Maiden Surname)					
		ပ္	Waverly Parker 19a. Informant's Name/Relationship (Type. Print) Elaine Parker /Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Adelina Road Prince Frederick, MD 20678)			
							cemetery				Date 21/07	20c. Location - City or Town, State Prince Frederick, MD			
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral S	a. 1	Sevel				1451 Dai	uneral Home es Beach Ro			rick, MD 2	0678	
or Vital Records, P.O. Box 68760,	Physician /Medicai Examiner	Examiner	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ase, or com e. List only	a	AI	the death. Do not e.		er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Inter	oximate val Between st and Death
			Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause Underlying that initiated events resulting in death) Last	b. Due to	Due to (or as a consequence of):										
	ficate be executed g physician and ts the burial-transit	edical Ex	resulting in death) East	l	Due to (or as a consequence of):										
	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown							1		23d. Date of delivery Month Day Year			Year
	quires that in signed by uld be deta	by	Trait ii. Other significant containating to death but not resulting in the underlying cause given in 1 at 1.												
	or Attending Physician: ifter death. Director: After this certifica in by the funeral director, p	Certification: To Be Completed	24a. Was an autopsy fir autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2								on of cause of				
Vita			25. Was case referred to medical examiner? 1												
Division or			27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28d. Linjury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work?												
Div			4 Homicide Getermined building, etc. (Specify) City or Town, State)												
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 ☐ M one)	edical Exa	miner: On the		examination and		vestigation, in my	ppinion, death occur		e, date ar	nd place, and d	ue to the o	
•	with Void	N	29b. Signature and title of	certifier	AR	Z	Mr)	29c. Licens	965	7	29d. Da	ate signed (Mo	nth, Day,	Year)
	2		30. Name and address of Charles Judg						Print)				/		
	Sta Regist	ate rar	31. Date filed (Month, Day	JUN (0 2007	Registra	Signature	K	Short!	p					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 RINEHART 06 25 1638 CHESTER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS-BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□ M 2□ F Dec 26, 1935 Director 214-30-7517 the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edicai Examiner must be notified at 1√ Yes 2 No MD Allegany Cumberland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21502 USA 12609 Iron's Mountain Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? X☐ Yes 2☐ No If Yes, Give Year or Dates: 1955-57 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Heatth and Mental Hygiene. Item 27 Is marked other than "natul other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PPG Industries 12 truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Virginia Cole Rinehart Darl White Rinehart ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 12609 Iron's Mountain Cumberland Nancy Rinehart wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Department of I Important: if ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/2007 SS Peter and Paul Cemetery MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) AnoxR **Physician** /Medical Examiner iac one Due to (of as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 687606

as the burial-trai after death.

Director: After this in by the funeral

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 25. Was case referred to medical examiner? မ 27. Manner of Death Certification:

Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE

> ☐Yes 2☐No 9 ☐ Unknown

> > 2 No

1 ☐ Yes

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

1 Inpatient

(Month, Day Year)

28a. Date of Injury

Due to (or as a consequence of)

5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

3 ☐ Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown 24a. Was an autopsy

1☐ Yes 2.X No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 2□No

Year

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 12 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Other:

1 □ Yes 2 □ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 SETON DRIVE SUITE MARK G. NEISON

M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

13

5 ☐ Pending investigation

6 ☐ Could not be

within 24 hours a

To the Funeral C

completely filled

Medical

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		ertificate of l			g. No	2.1500		
8	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Dav Year	3. Time of Death 9:06 A M		
200	/Medic	al	Lucille Payne 4a. Facility Name (If not institution, give s			June 4b. City, Town, or Location of Death			4c. County of Dea			
	Examin	er	Prince George's I	1			Prince George's					
- Sagar	Funeral	e-	Social Security Number 6. Sex	7. Age (In yrs. las) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign puntry)		
5	Director		219-54-8653	M 2√2 F 81	Yrs.			July 22,	1925 Was	hington, DC		
036	/land iow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
	e Mar a-f sh tified	ctor	MD Prince Ge	erly			1 No 2 No					
	vith th	Funeral Director	10e. Street and Number 3303 Belleview Aver	10f. Zip Code 20785			10g. Citizen of What Country? USA					
	ns 23a must	era	11. Marital Status	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - Ame					
	be filed within 72 hours after death with the Maryland ttal Hyglene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2½ No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, Whi	te, etc. Thite		
2 0	72 ho 'natur dical i	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dec (Giv	edent's Usual Occup le kind of work done o DO NOT use retired	ation during most of work	ring 1	6b. Kind of Business	Kind of Business/Industry		
2	within sne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	(1-4or 5+) Sec		1)	De	ept. of Ag	ot. of Agriculture		
Baltimore, Maryland 21215-0036	filed Hygie	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
	uld be Vienta Irked o	To B	John Payne		Ruth Martin							
	es 1 and 2 should be fi of Health and Mental H f item 27 is marked ot r other traumatic ever		19a, Informant's Name/Relationship (Ty			-			City or Town, State,			
	1 and Health em 27		Rebecca A. Wilson-D			Belleview consition (Name of ematory or other place			Oc. Location - City or	20785 r Town, State		
	permit. Pages Department of I Important: If it any Injury or o once.		1 ☐ Burial 2XXCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Metro	olit	n Crematory	0/1		lexandria,			
Ba	permit Depar Impor any In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781									
			23a Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death									
	Physician /Medical	l' i	Immediate Cause (Final disease or condition resulting in death)	Bus to lorge a conseque								
	Examiner			Due to (or as a consequence of):								
	<u> </u>	ner	Simulated list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence oi):								
	recuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque								
	tificate be executed ig physician and as the burial-transit			· · · · ·								
_	tificate ng phy: as the	Medical		J								
Box	eath cert attending for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnand 1□Live birth 2□Fetal c	3 □Ectopic pregnancy			23d. Date of de Month	elivery Day Year			
	he dea the at	Physician//	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5	☐ Other (specify) _			_			
P.0	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	y Ph	Part II. Other significant conditions co	underlying cause giv	en in Part I.	23e. Did toba	3e. Did tobacco use contribute to the cause of death?					
Records,	equires en sign ould be	ed by					1 ☐ Ye	s 2□No 3□F	3 Probably 4 ☑ Unknown			
မင္ပင	law re las be	Completed					14	24a. Was an autopsy	prior to	autopsy findings available completion of cause of		
n or Vita		Con		1 Yes 2	performed? death? 1 Yes 2 No 1 Yes 2 No							
	Physician: The lave this certificate has all director, page 2	Be	25. Was case referred to medical examiner?	Hospital: 1 □ Inpatient 2 ☑ €	R/Outnati	ent 3 DOA Oth	26. Place of Death (Check only one) Pri 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
	Attending Physician: r death. ector: After this certifica	n: To	27. Manner of Death		28b. Time Injury	of 28c. Injury at 28d. Describe how injury occurred						
	tendin sath. or: Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1□	Yes 2 □ No					
	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C										
	To the To the To the Comple	Me	29b. Signature and title of certifier	29c. License number			29d. Date signed (Month, Day, Year)					
	_			the	4	25	8957		6-17-07			
	50		30-Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gary Little 3001 Hogyetal Drive Cheverly MD 20785									
	Sta Registi		31. Date filed (Monte Day Year)	32. Registrar's Sitgatu			,					